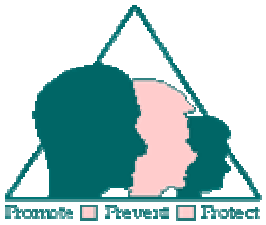

Utah Department of Health

Utah State Planning Grant

Covering the Uninsured

HRSA Final Report

August 19, 2004

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Utah State Planning Grant

Covering the Uninsured

Utah Department of Health
Division of Health Care Financing

Program Director
Michael Deily

Project Director
Chad Westover
Michael Hales

Project Staff
Rita Hanover, Project Manager
Shane Carlson, Project Manager
Rachel Fischer, Health Policy Consultant
Kellie Roberts, Health Policy Consultant
Jennifer Francom Soliai, Health Policy Consultant
John L. Strong, Project Completion Specialist

Table of Contents

EXECUTIVE SUMMARY.....3

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES 9

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE.....22

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE.....42

SECTION 4. OPTIONS FOR EXPANDING COVERAGE.....51

SECTION 5. CONSENSUS BUILDING STRATEGY.....74

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES.....79

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT 85

APPENDIX : BASELINE INFORMATION.....88

EXECUTIVE SUMMARY

In 2001, Utah was one of 20 states awarded a unique opportunity to develop proposals to provide health care access for Utah's more than 199,000 uninsured residents. With a $1.1 million grant from the US Health Resources and Services Administration (HRSA), the Utah Department of Health intensively collected statewide data on the uninsured, and actively sought input from Utah's businesses and citizens to accomplish the grant goals.

The objective of the grant was to determine the most effective methods to provide access to high quality, affordable health care to residents who earn up to 200% of the Federal Poverty Level ($37,700 for a family of four). Four workgroups were used to employ collected data, project staff and technical consultants to design proposals that were presented to a diverse steering committee overseeing the project.

By forming a statewide partnership of individuals with a stake in Utah's health care system - including the uninsured and those from public and private entities - the expectation was to develop at least three viable proposals for covering Utah's uninsured. This was achieved with the following activities:

- Perform community needs assessments via the 2000-2001 Health Status Survey and community focus groups in order to obtain a detailed description of Utah's uninsured population
- Assess the needs and attitudes of Utah businesses with a statewide employer health insurance survey
- Identify Federal barriers that limit states' abilities to implement local, workable solutions
- Provide market research and actuarial assessment of viable options designed by the partnership
- Prepare a report to the US Secretary of the Department of Health and Human Services, as well as the Utah Legislature, which will be used to guide future policy and legislation to address this critical issue

Funding from HRSA permitted Utah to research and identify the most feasible option, allowing the state to expand access to affordable health insurance coverage to more citizens of Utah. This report describes activities undertaken by Utah's Covering the Uninsured 2002 (CU2002) HRSA State Planning Grant. The report has been updated to reflect completion of the 2001 Utah Health Status Survey and Discrete Choice Analysis of health coverage proposals. Under the guidance of our CU2002 Steering Committee and in partnership with stakeholders

throughout the state, we conducted a number of data collection and policy planning activities through an extension of the HRSA State Planning Grant. These activities also reflected the original goals of the project:

- Gain a greater understanding of the uninsurance problem in the State of Utah
- Develop proposals for addressing the problem of the uninsured
- Develop recommendations for Federal action to support State efforts to provide health insurance for the uninsured

Data Collection Activities

A survey of 7,520 Utah households was conducted to obtain detailed health coverage information on 24,088 individuals. The 2001 Health Status Survey was completed, and results of this survey are included in this report.

A survey of Utah employers was also completed. Businesses operating in predominately rural or urban areas with 1-9, 10-49, 50-99, or more than 100 employees were surveyed to provide previously unavailable information comparing the characteristics of those companies presently offering coverage to those companies that do not offer health care coverage to their employees. This survey also provides valuable information about the factors affecting an employer's decision to offer health care coverage.

Policy Planning Activities

The project organized a number of efforts to develop viable policy options for the State of Utah. The project steering committee played a key role in this process by authoring the CU2002's Guiding Principles. The project's guiding principles are:

- Make health care accessible to the most people possible, under 200% FPL
- Achieve political and fiscal viability
- Cover greatest need first
- Preserve private sector investment in the financing of health care
- Promote responsibility for the cost of health care among individuals, employees, insurance carriers and health care providers
- Identify solutions that are workable and acceptable to target population

Workgroups, comprising community representatives, were formed to explore public, private and cost-sharing approaches to expanding coverage. These workgroups were charged with developing viable proposals that were brought before and evaluated by the steering committee. A number of options were explored including a Primary Care Network (PCN), a Children's Health Insurance Program (CHIP) expansion to parents, a Medicaid expansion to parents and an employer cost-sharing model.

Proposals, to expand CHIP coverage to parents earning up to 200% of FPL (1115 Waiver) or to expand Medicaid coverage to parents earning up to 100% of FPL (1931 Expansion), were evaluated extensively. The most significant barrier to these two proposals was funding.

We also examined the cost-sharing model currently in use by Muskegon County, Michigan as a possible adjunct to our PCN proposal. That cost-sharing model uses an equally distributed three-way cost share between state, employer and employees to bring insurance coverage to within the reach of businesses that employ a disproportionate number of low income workers. Community leaders and stakeholders took part in a two-day workshop/discussion with the director of Muskegon County's program, Vondie Woodbury, in Salt Lake City in November 2001.

On February 9, 2001, Health and Human Services (HHS) Secretary Tommy G. Thompson formally approved Utah's request for a Federal 1115 Medicaid demonstration waiver to expand benefits for primary care and preventive services to approximately 25,000 residents who otherwise would not have access to health coverage. This waiver allows Utah's Medicaid program to provide a limited medical package (Primary Care Network or PCN) to working adults whose income is less than 150 percent of the Federal Poverty Level (FPL). The PCN model is akin to a "family physician" model, which provides basic and general health care services to people seeking assistance for screenings to identify or prevent illness and disease or needing treatment for common illness or injury. It will also provide care for the management of chronic disease. The Primary Care Network was implemented on July 1, 2002, for a five-year demonstration.

In connection with the waiver, Governor Michael O. Leavitt signed into law House Bill 122 enabling even more uninsured working Utahns to obtain health coverage similar to the new Medicaid waiver through a partnership with employers and the private insurance market. Information from CU2002's focus groups and key informant interviews was used to inform and guide development of this partnership.

We conducted a Discrete Choice Survey of individuals and employers to gauge enthusiasm for the various health coverage options under consideration. Discrete Choice Analysis (DCA) uses advanced modeling techniques to provide a better understanding of the values and preferences of a target population. This research method employs sophisticated mathematics, theories in human choice behavior, and scientific design technologies. It involves collecting data from a carefully controlled sample to examine the influence that various factors have on the choices people make. The information is then used to build simulations that identify target groups who react differently to changes in various insurance product packages and predict how changes in key factors (i.e. benefit packages, cost sharing, provider availability, etc.) will influence future choices (uptake rates).

The product packages included in our Discrete Choice Survey described these proposals for providing health care to the presently uninsured. Individual respondents were stratified and grouped by income level, employment status, rural versus urban residence, health status, and parental status. Employer respondents were stratified and grouped by number of employees, urban or rural location, and industry. Respondents were asked to choose among various health insurance options with varying levels of benefit and cost attributes. The results of this project will help us to identify key factors affecting the decision to take up a specific benefits package across a range of price points. These findings will also guide the development of proposals and

recommendations designed to minimize "crowd-out" by identifying how insured respondents might "choose" between their present coverage and several proposed options.

Results of the Discrete Choice Analysis indicated:

- The demand for new plans is strong but highly sensitive to the specific configuration of the plans available. Customers compare and switch among plans based on the features of a plan and how that plan looks in comparison to other plans. Changes in one plan can have a large impact on the demand for other plans.
- A PCN plan with limited benefits, low costs, and service provided through community health centers should form the basis of any suite of health plans offered to the market. This plan should be widely advertised with messages directed at individuals who place a limited value on extra benefits and who currently don't carry insurance. A PCN plan should increase health coverage among these groups without encroaching on markets for other health coverage options (new or traditional). In addition, offering a basic PCN plan places other plans (in particular the cost-sharing plan) in a more positive context among individuals and employers alike.
- A PCN plan should be complemented with one or more employer cost-sharing plans with service available from approved providers. Employer monthly premiums should be kept to a minimum and benefits kept at moderate levels. Individuals may elect to pay additional amounts to get access to additional benefits.
- Dental, hearing and vision care appear to be the most attractive additional benefits to most individuals. Mental health care is generally less important and sometimes seen as a negative option.
- Waiver plans appear to be generally less successful, unless offered through an employer at which time they attract share from the employer cost-sharing plans. In addition, employers prefer cost-sharing plans to waiver plans in part because the cost-sharing plans have generally lower employer premiums but also because employers are attracted to plans where employees pick up at least some of the cost of health care – whether that be contributions toward the premium or higher payments toward inpatient medical expenses.

Regarding Federal action to support state efforts to provide health insurance for the uninsured, recommendations are included as part of our Final Project Report. Specifically, the Primary Care Network (1115 Waiver) was recommended and has been implemented (since July 1, 2002). This report will mention some of the results of this demonstration; however, the main focus of this report will be on how the State of Utah determined the PCN demonstration was the most appropriate program to accomplish the goals and guiding principles the team set out to accomplish.

<u>Uninsured</u>

Overall, 8.67% (approximately 199,100 individuals) of Utah's total population are uninsured. 6.51% (approximately 50,600 individuals) of children in Utah are uninsured. The highest rate of uninsurance among Utahns is found among individuals, whose household income is less than $25,000 annually (46.84% uninsured). 13.8% of individuals 18 – 34 years old are uninsured.

This group represents 45.9% of all the uninsured individuals in Utah. Utah males (52.4% uninsured) are more likely to be uninsured than females (47.6% uninsured). Individual adults who have "Never Married" are most likely to be uninsured (15.2%). "Unemployed" adults (18.3% uninsured) and "Students" (14.7% uninsured) are most likely not to have insurance. Also, Hispanic residents are three times more likely to be uninsured (25.84%) than Non-Hispanic residents of Utah (7.19%).

Recommendations to States

For policy planning, Utah has four main recommendations:

First, take advantage of national databases. States should take the time, up front, to understand information that's already out there and take advantage of individuals who know how to access and interpret that information. It's difficult for states to get large enough data samples to accurately make strong conclusions. Many national databases are available that complement, solidify, or help to clarify studies done in states. The State Planning Grant meetings were an invaluable source of information on these national databases (CPS, MEPS, etc.).

Second, get qualitative data to augment the numbers from the quantitative data collected. Though quantitative data is more objective, qualitative data can be an effective way to interpret the numbers.

Third, collaborate. Talk with other states and among community agencies in your own state about what studies they have done and the methodology by which they did it. Share data with each other. Don't reinvent the wheel.

Fourth, hire a national consultant who already has a thorough knowledge of the national environment and what other states have done.

Recommendations for Federal Actions

Additional research to assist in identifying the uninsured or developing coverage expansion programs should be conducted. Studying different uninsured patterns would prove to be very useful. Below are several examples of potential research studies:

- What kind of patterns lead to being uninsured?
- On average, how long are people uninsured?
- What are people's needs during periods of being uninsured?
- How can the State target financial relief to periodic uninsureds, in order to assist them to make it to the next stable insurance time? (i.e. frequently between jobs – assistance w/ COBRA)
- What are the characteristics of "chronically uninsured" people?
    - Uninsured choose not to be insured
        - Financially OK
        - Healthy and do not need insurance
    - Uninsured are so sick that nobody will insure them

- What are the exemptions of covered benefits?
    - Study of pre-existing condition in new (underwritten) health policies …
        - Provider will "insure everything except your 'bad' knee at the normal rate"
        - Are health providers more willing to insure "higher risk" patients with certain exclusions?
    - Study of health policies where there are no exemptions to covered benefits …
        - Provider must cover all illnesses
        - If too costly, are health providers unwilling to take these financial risks?

Section 1. Summary of Findings: Uninsured Individuals and Families

The most precise and up-to-date information on Utahns comes from the Utah Health Status Survey *(UHSS)*. The UHSS has been conducted every five years since 1986, and has a much larger sample size than national surveys on the subject. The 2001 UHSS was a telephone survey of 7,520 households throughout the State and included detailed health status information on 24,088 individual Utahns living in those households. In comparison, the 2001 Current Population Survey (CPS) included only 604 Utah households. The information gathered on individuals included in the survey was provided by the adult (age 18 or older) of the household who had the most recent birthday. Data collection was conducted between May 15, 2001 and November 15, 2001. Some notes on the 2001 UHSS:

- The 2001 UHSS collected information on the type of coverage for every person in the household.
- Used CPS-type classification for type of insurance (e.g., private/employer, Medicaid, Medicare).
- Recorded all types of insurance coverage for each person (not just primary type of coverage).
- Asked specifically about Children's Health Insurance Program (CHIP), including a question "preamble" that explains that CHIP is a government-sponsored program for children of low-income working parents.
- Asked two verification questions (insurance card size and frequency of card replacement) to correctly classify whether persons are covered by Medicaid.
- Asked whether or not the insurance plan(s) covering persons in the household cover ONLY special conditions, such as diabetes or breast cancer. This is done to distinguish these plans from more comprehensive plans, and get a better measure of overall health insurance coverage.
- A follow up question was asked to "no" responses (indicating that they did not have insurance) to determine all possible sources of insurance, and verify that none of them is relevant in the household.
- Follow up questions were used to determine the reasons why individuals (who lacked health insurance) may not be covered. That is, instead of reciting the list and asking for the primary reason, each reason was asked separately, for each person in the household, and asked whether that reason applied to them.
- Several questions have been added to improve the ability to measure 1) access to medical and mental health, and dental care, 2) employment status, 3) employee take up of insurance plans offered at work, 4) ability to afford prescription medicines, and 5) fear that seeking health care or government assistance would jeopardize US residency status.
- Finally, the household income measure has been improved in three ways: 1) smaller income categories, 2) an additional question about whether income was steady over the past year, and 3) an additional follow-up question about the prior month's income for persons whose annual income is not steady over the course of the year. This change will decrease measurement error for poverty status.

1.1 What is the overall level of uninsurance in your State?

Overall, 8.67% (approximately 199,100 individuals) of Utah's total population are uninsured. In addition, 6.51% (approximately 50,600 individuals) of children in Utah are uninsured. *(Utah Health Status Survey, 2001, UHSS)*

1.2 What are the characteristics of Utah's uninsured population?

Income: The highest rate of uninsurance among Utahns is found among individuals, whose household income is less than $25,000 annually (46.84% uninsured). *(UHSS)*

2001 Uninsured by Annual Household Income		
Annual Household Income	**Percent Who Are Uninsured**	**Distribution of Uninsured**
Under $15,000	27.05%	15.38%
15,000 - 25,000	19.79%	21.03%
25,000 - 35,000	13.19%	24.02%
35,000 - 45,000	8.02%	15.98%
45,000 - 55,000	7.53%	9.83%
Over $55,000	2.77%	13.76%
Total	8.74%	100%

Of the approximately 50,600 uninsured children (0-18) in Utah, approximately 35,600 live in households with annual incomes at or below 200% FPL. *(UHSS)*

Poverty Level of Child's Household	**Total, All Children Age 0-18**	**Percentage of Children Who Lacked Insurance Coverage**
At or Below 200% of Poverty	38.38% (298,500)	11.94% (35,600)
201% or Above	61.62% (479,300)	3.24% (15,500)
Total, All Children Age 0-18	100% (777,800)	6.51% (50,600)

Age: 13.8 percent of individuals 18-34 years-old are uninsured. This group represents 45.9% of all the uninsured individuals in Utah. Additionally, 24.8% of all uninsured are under the age of 18; 20.0% are 35-49 years; 8.6% are 50-64 years; 0.7% are over 64 years. *(UHSS)*

2001 Uninsured by Age		
Age range	**Percent Who Are Uninsured**	**Distribution of Uninsured**
17 + under	6.8%	24.8%
18-34	13.8%	45.9%
35-49	9.2%	20.0%
50-64	6.6%	8.6%
65 + over	0.7%	0.7%
Totals	8.7%	100%

Gender: Utah males are more likely to be uninsured than females. Of the uninsured, 52.4% are males while 47.6% are females. *(UHSS)*

2001 Uninsured by Gender		
Gender	**Percent Who Are Uninsured**	**Distribution of Uninsured**
Male	9.1%	52.4%
Female	8.3%	47.6%
Totals	8.7%	100.0%

Family Composition: Individual adults who have "Never Married" are most likely to be uninsured (15.2%), followed by those who are "Divorced, Separated, Widowed" (12.2%). Respondents who are "Married, living as married" are the least likely to be uninsured (7.6%). However, because of the large percentage of people belonging to the "Married, living as married" category, this group accounts for 54.7% of all the uninsured in the state. *(UHSS)*

2001 Uninsured by Marital Status of Utah Adults		
Marital Status (age 18 and over)	**Percent Who Are Uninsured**	**Distribution of Uninsured**
Married, living as married	7.62%	54.70%
Divorced, Separated, Widowed	12.20%	15.80%
Never Married	15.23%	29.50%
Totals, Utah Adults	9.56%	100.0%

Health Status: Individuals in "Fair/Poor" health are more likely to be uninsured (9.3%) than those reporting to be in "Good/Very Good/Excellent" health (8.6%). However, because of the large percentage of people belonging to the "Good/Very Good/Excellent" category, this group accounts for more than 90% of all the uninsured in the state. *(UHSS)*

2001 Uninsured by Health Status		
Health Status	**Percent Who Are Uninsured**	**Distribution of Uninsured**
Fair/Poor	9.32%	9.70%
Good/Very Good/Excellent	8.60%	90.30%
Totals	8.67%	100.0%

Employment Status: "Unemployed/Other" adults are most likely to be uninsured (15.7%). Students (14.7%), part-time workers (12.2%) and homemakers (10.9%) are the next most likely groups to be uninsured. 9.5% of full-time working adults are uninsured. Because the majority of people are employed full time, this group accounts for 57.3% of all the uninsured in the state. Retirees are least likely to be uninsured (1.6%). *(UHSS)*

2001 Uninsured by Employment Status, Utah Adults Age 18+		
Employment Status	**Percent Who Are Uninsured**	**Distribution of Uninsured**
Full Time	9.5%	57.3%
Part Time	12.2%	17.6%
Retired	1.6%	2.2%
Keeping House	10.9%	10.8%
Student	14.7%	4.1%
Unemployed/Other	15.7%	8.0%
Total, Adults 18+	9.6%	100.0%

Availability of Private Coverage: The 2002 Health Insurance Market Report (Utah Insurance Department) evaluated Utah's health insurance market. The study focused primarily on the comprehensive health insurance portion of the commercial market. The typical Utah resident has an employee group policy with an HMO-style plan administered by a domestic health insurer. 37.24% have commercial health insurance plans, while 33.65% have employer-sponsored plans. Of these employer-sponsored plans, 21.35% have plans administered by commercial insurers; 5.47% are on the Public Employee Health Program (PEHP); 4.91% are on the Federal Employee Health Benefit Plan (FEHBP); 1.92% are on other known employer plans. *(Utah State Insurance Department, USID)*

Estimate of Private Health Insurance Coverage for Utah in 2001

Coverage Type	Population Estimate	Percent of Population
Commercial Health Insurance Plans (State Regulated)	**855,018**	**37.24%**
Group	742,584	32.34%
Individual	112,434	4.90%
Employer Sponsored Plans (ERISA Regulated)	**772,502**	**33.65%**
Plans Administered by Commercial Insurers	490,187	21.35%
Public Employee Health Program (PEHP)	125,469	5.47%
Federal Employee Health Benefit Plan (FEHBP)	112,838	4.91%
Other Known Employer Plans	44,008	1.92%

Availability of Public Coverage: Approximately 10.3% of all Utah residents receive their health insurance coverage through the State Medicaid program. The unique number of enrollees is about 223,800 people under the age of 65. This represents the unique number of individuals

enrolled, not current enrollment. In general, Medicaid coverage is available to pregnant women (133% FPL), children under 6 (133% FPL), children 6-18 (100% FPL) the disabled (100% FPL), and the Medically Needy (spend down allowed to $382/mo. per individual). Medicare covers approximately 14.53% of Utah's population. As of January 2004, Utah's CHIP currently enrolled approximately 26,500 children, and determines eligibility up to 200% FPL. As of December 2001, CHIP discontinued continuous enrollment. CHIP accepts new applicants during Open Enrollment periods. For Fiscal 2004, Utah has funds to provide for a monthly average of 28,000 children. *(UHSS)*

Race/Ethnicity: Data from the 2001 UHSS shows Hispanic residents are more than three times as likely to be uninsured (25.84%) as Non-Hispanic residents of Utah (7.19%). Nationwide, 77% of Blacks, 65% of Hispanics, and 79% of Whites have health insurance offered through their employer. But the percentage of workers who decline offers is about 15% for each of these groups. Finally, 81% of Blacks, 67% of Hispanics, and 89% of White workers have health insurance coverage.

2001 Percentage of Persons Who Were Uninsured By Hispanic Status			
	Percent of Utah Population	**Percent Who Are Uninsured**	**Distribution of Uninsured**
Hispanic	8.99%	25.84%	26.20%
Non-Hispanic	91.01%	7.19%	73.80%
Total	100%	8.67%	100%

Immigration Status: Utah's foreign-born population is approximately 158,700 (7.1% of total population). The US Census Bureau projects that Utah's population will increase by 31% between 2000 and 2025 to 2.9 million. Currently, the illegal resident population consists of approximately 15,000 people, which is 0.67 percent of Utah's total population. With a 31% increase in the total population, the illegal resident population will increase to approximately 19,700, which will be 0.68 percent of Utah's total population. We can assume that most illegal residents of Utah are uninsured, as they are not eligible to receive public assistance, or may not qualify for employer benefits. An MSNBC publication stated that Utah's illegal resident population could be as high as 75,000. *(U.S. Census Bureau 2000)*

Immigration in Utah's Population

State Population	2,233,169
Population Increase 1990-2000	510,319
Foreign-Born Population	158,664
Percent Foreign-Born	7.1%
Illegal Resident Population	15,000
2025 Population Projection	2,883,000

US Census Bureau 2000

Geographic Location: The Wasatch Front is a 100-mile corridor comprised of several urban areas including Salt Lake City, Ogden, Orem and Provo. 76.25% of the population of Utah lives along the Wasatch Front. *(UHSS)*

The Utah Health Status Survey found the highest percentages of persons without health insurance coverage live in frontier areas of the state. 10.15% of rural Utahns are uninsured, while 8.2% of urban Utahns (those living along the Wasatch Front) are uninsured. Because 76% of Utahns live along the Wasatch Front, this location represents 72% of all uninsured in Utah.

Percentage of Persons Who Were Uninsured By Residence in Wasatch Front Counties

	Percent of Utah Population	Percent Who Are Uninsured	Distribution of Uninsured
Wasatch Front (Urban)	76.2%	8.2%	72.2%
Non-Wasatch Front (Rural)	23.8%	10.2%	27.8%
Total	100%	8.67%	100%

Number and Percentage of Uninsured Persons by Local Health District

Health District	Total Population	Insured Persons	Uninsured Persons	% Without Health Insurance Coverage
Urban Districts				
Davis County	244,844	235,246	9,600	3.92%
Salt Lake	918,279	833,011	85,300	9.29%
Utah County	385,690	357,848	27,800	7.22%
Weber-Morgan	207,864	187,028	20,800	10.02%
Rural Districts				
Bear River	138,600	129,742	8,900	6.39%
Central	67,207	59,162	8,000	11.97%
Southeast	52,817	45,697	7,100	13.48%
Southwest	147,370	128,911	18,500	12.53%
Summit	31,279	28,935	2,300	7.50%
Tooele	44,430	41,860	2,600	8.04%
TriCounty	41,640	35,920	5,700	13.74%
Wasatch	15,947	14,645	1,300	8.18%
State Total	2,295,967	2,098,005	197,900	8.67%

2001 Utah Health Status Survey

Duration of Uninsurance: Data from the 2001 UHSS indicates that the majority of uninsured in Utah fall into two categories: (1) those that have been uninsured for less than six months (23.9%) and (2) those that have been without insurance for four years or longer (37.4%).

Duration Uninsured	Percentage Distribution of Persons with No Health Insurance Coverage
< 6 Months	23.9%
6 months - < 1 year	9.2%
1 year - < 2 years	15.9%
2 years - < 3 years	7.2%
3 years - < 4 years	6.4%
>= 4 years	37.4%
Totals	100%

1.3 Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion options?

The State Planning Grant Steering Committee developed guiding principles for targeted coverage expansion options. Priorities included those with the greatest need, up to 200% of the Federal Poverty Level. Based on the 2001 UHSS, sub-populations with higher percentages of people without health insurance were:

- Young adults age 19-26 years old (15.3% without health insurance)
- Adults without a high school education (34.5%)
- Persons in households with incomes less than $20,000 a year (22.0%)
- Unemployed adults (18.3%)
- Persons of Hispanic ethnicity (25.8%)
- Persons living outside the urban Wasatch Front (10.2%)
- Residents of specific rural health districts (e.g., Tricounty – 13.7% and Southeastern Utah – 13.5%)
- Persons who reported "fair/poor" health status (9.3%)

1.4 What is affordable coverage? How much are the uninsured willing to pay?

When defining "affordable coverage," studies varied according to geographic location (rural versus urban), current income, and current amount being paid toward health. Rural residents' "affordability" estimates range from $50-$300 per month per family. Urban residents' estimates

range between $50-$700 per month per family. Many of these affordable amounts are based on what individuals are currently paying for coverage. A 2002 National Bureau of Economic Research (NBER) paper, by Bundorf and Pauly, noted that depending on the definition, health insurance was affordable to between one-fourth and three-fourths of the uninsured in 2000. Although income is related to the purchase of coverage, it is not perfectly related to insurance status. Income is not the only factor driving decisions. Due to the cost vs. benefit of owning an insurance policy, many choose not to pay the monthly premiums, electing to pocket the money and "take their chances that they are healthier than the average person and will beat the odds."

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

Persons do not participate in public programs for the following reasons:

- Do not like participating in government programs
- Too much of a hassle
- Do not believe they will qualify
- Do not believe they need health insurance
- Able or want to provide for own health needs
- Do not understand available programs

In addition to the above-mentioned reasons, especially people living in rural areas where citizens are more acquainted with each other, the "stigma" associated with being on welfare or assistance is motivating enough to avoid any type of program.
(Wirthlin Worldwide, Utah Department of Health, Covering Kids, Research Project, November 2002)

1.6 Why do uninsured individuals and families disenroll from public programs?

From a 2002 study conducted for Utah's CHIP program, the following results are the most common reasons for disenrollment:

- Child moved to private insurance (60%)
- Family makes too much money (21%)
- Child moved to Medicaid (8%)
- Child is too old (8%)
- Other reasons (3%)

1.7 Why do uninsured individuals and families not participate in employer sponsored coverage for which they are eligible?

Per focus groups and key informant interviews conducted, the most common reason individuals do not participate in employer sponsored coverage is "unaffordability."

"Affordability is number one. By the time people pay car insurance, rent or mortgage, they don't have anything left. The wages aren't magnificent in this area." *(Rural Surgeon)*

"They pay rent and buy food first. Premiums are too high." *(Rural Clinic Director)*

Unless premiums are covered 100% by the employer, there will always be a group of people who, for value reasons, will not purchase insurance.

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

Yes, when employers do not offer group insurance, rarely do employees seek individual insurance. When focus group participants were asked why they were uninsured, their top two reasons were "affordability" and "employer did not offer insurance." When coverage was not offered through the workplace, rarely did the employee seek coverage through individual means.

The Utah Health Insurance Association (UHIA) commissioned a pubic opinion and market research survey of Utah residents during November 2001. The results of its study suggested that uninsured respondents placed less importance on having an employer who offers health insurance. Most insured respondents (84%) feel that employer-sponsored health insurance is very important, whereas only 64% of uninsured respondents feel that health insurance through their employer is important. Still, 10% of insured respondents and 8% of uninsured respondents indicated that it is not very important that their employer offer health insurance.

1.9a How likely are individuals to be influenced by premium subsidies?

From focus group studies and key informant interview results, for uninsured individuals to take advantage of financial assistance, subsidies would have to be substantial and provide most or all of the individual's share of the premium. In addition, there would be a greater chance of utilizing premium subsidies if the assistance were available when premiums are due rather than reimbursable at the end of the year. One example is the state's Covered at Work program. Even with a $50/month subsidy, we currently only have 55 enrollees.

1.9b How likely are individuals to be influenced by tax credits or other incentives?

Individuals are not highly likely to be influenced by tax credits or other incentives. If this program were to work, individual tax credits would need to be refundable to help low-income workers. For the incentive to be effective, awareness that it exists and how to claim the incentive would need to be readily available. The Center on Budget and Policy Priorities estimates that 15% to 20% of those eligible for the Earned Income Tax Credit (EITC, a refundable income tax credit which has been around for 30 years) miss out on the benefit because they do not know they qualify, don't know how to claim the credit, and do not know where to find free filing assistance. In addition, more than 15% of Federal EITC recipients fail to claim the state EITC for which they are eligible. *(Urban Institute, 8/29/01)*

1.9c How likely are individuals to be influenced by health insurance mandates?

From the Partner Summit, the option of "mandating" health insurance was deemed "not viable" and thus was not pursued in greater detail during the focus groups and key informant interview discussions. In previous legislation, Utah imposed an automobile insurance mandate; however, approximately 9% of Utah automobile owners remain uninsured. Compliance with seatbelt laws follows a similar trend to that of automobile insurance. Compared to automobile insurance, Utah's uninsured rate is already lower for health insurance.

1.10 What other factors besides affordability prevent the purchase of health insurance?

Besides education and language, based on our findings from focus groups and key informant interviews, the following are the main factors for the uninsured not purchasing insurance:

- Lack of need for health insurance due to good health
- Limited resources (i.e. children's needs – food, clothing, etc.)
- Small businesses and self-employed cannot afford the high premiums (farmers mentioned specifically in rural areas)
- Wages are too low in the area for affordability, but make too much to qualify for public programs ("working poor")
- It is a priority issue for some – health insurance is not worth the price
- People are not aware of the resources (government and private) available to them
- Many are unemployed and lack access to coverage
- There are not many employment options
- There are many illegal immigrants who cannot get help
- Employment status is part-time (often employer's choice), seasonal, or migrant and this disqualifies them from employer-sponsored coverage

1.11 How are the uninsured getting their medical needs met?

First, it should be noted that many of the uninsured's medical needs are not being met. The 2001 Utah Health Status Survey indicated that even among the insured, 11.4% were unable to get needed medical, dental, or mental health care in the previous 12 months. Primary reasons for access problems were "can't afford" (7.19%), "service not covered by health insurance" (6.91%), and "could not find services in my area" (2.69%).

From the focus group and key informant respondents, the following are the most likely places uninsured would go to seek medical care:

- Hospital charity care programs
- Religious organizations
- Family members
- Government programs
- Doctors who volunteer their services
- Local clinics (i.e. Community Health Centers)

1.12 What are the features of a minimum benefit package?

From multiple sessions, focus group participants were asked to describe their ideal health insurance plan, but include only the 6 most important benefits. The 6 benefits most generally agreed upon include:

- Physician services
- Inpatient hospital
- Emergency room
- Prescription drugs
- Lab and x-ray
- Immunizations

When we noted the question, "If you had to create your own benefit package, what would be the top five benefits that you would include?" The most common answers were:

- Physician Services
- Emergency room
- Prescription Drugs
- Lab and x-ray
- Inpatient hospital

We found that Utah consumers generally perceive insurance value according to the number of highly utilized benefits that are included in the benefit package and not necessarily those that would incur the highest cost. The catastrophic protection generally perceived for other insurance markets (home, auto) was not recognized for health insurance. Focus group participants wanted their health insurance to cover the services they use the most.

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

"Underinsured" is a relative term, depending on the income of the individual and the care needed. Therefore, it is difficult to quantify and objectively define. Underinsured could be any kind of coverage that leaves the individual vulnerable to financial hardship.

A couple of general definitions for "underinsured" include: "any time a medical condition threatens economic viability," or "any time a medical condition is not treated because it is not covered." Another factor to consider is the means and needs of the individual – a low-income person could purchase a policy with a high deductible and low premiums. This situation would represent underinsurance in that the out-of-pocket payments would be so high relative to income that needed health care would likely be neglected.

One focus group participant felt that she was underinsured when her catastrophic plan didn't cover a $10,000 surgery because it put her in financial hardship.

Focus group participants provided these perspectives defining "underinsured:"

"Any time medical bills for conditions or procedures that aren't covered by insurance threaten to bankrupt a person."

"Any time a medical condition is not treated because it is not covered."

"It depends on the means and needs of the individual: a low-income person could purchase a policy with a high deductible and low premiums. This could turn out to be underinsurance because the out-of-pocket costs would be so high they couldn't afford to go to the doctor when they needed to."

This same question was then asked to the key informant interviewees and had various responses. Several of these responses include:

"When the insurance company pays far below the cost of coverage, and when the insurance plan is oversold and the patient doesn't receive the coverage that he/she thought was included in the plan." – *Hospital CEO*

"When someone is faced with a catastrophic incident and doesn't have coverage, which ends in bankruptcy or financial ruin." – *Utah Legislator*

"For people who can't afford an $80 office visit, underinsured would be first dollar coverage unavailable, so it's dependent on one's financial resources." – *Legislator*

"Someone that doesn't have the level of healthcare coverage needed to maintain or receive adequate health services. It may be someone without insurance or someone that doesn't have the type of insurance that would cover the basic needs." – *Clinic Manager*

"When the company doesn't pay for anything and the patient may as well not have the coverage. I have seen that with two programs here." – *Dentist*

Section 2. Summary of Findings: Employer-based Coverage

Utah-specific employer information was obtained using surveys and key informant interviews. Surveys included: 1) the 2000 Medical Expenditure Panel Survey, Insurance Component (MEPS-IC 2000 and 2001), 2) an Employer Survey conducted by the Utah Department of Health State Planning Grant (SPG) staff through a Utah public opinion and marketing research company, and 3) an Employer Discrete Choice Survey conducted by the SPG staff through an international market research company. Key informant interviews were conducted with insurance planners and owners of businesses representing a cross section of Utah companies with varying benefit packages.

Survey Methods

MEPS-IC

The Medical Expenditure Panel Survey, Insurance Component (MEPS-IC) is an annual survey, of establishments, that collects information about employer-sponsored health insurance offerings in the United States. The List Sample is selected from a list of private-sector establishments (with at least one employee) that is developed and maintained by the Census Bureau. The sample allocation and design of the MEPS-IC List Sample also supports reliable state-level estimates of establishment characteristics, employee characteristics, and premiums and employee contributions for those enrolled in employer-sponsored health insurance plans. The MEPS-IC has a minimum sample size goal of 600 for each of the states included in the survey.

Each of the private-sector establishments is initially prescreened by telephone to obtain the name and title of an appropriate person in each location to whom a MEPS-IC questionnaire will be mailed. These questionnaires will verify the addresses, identify businesses that no longer exist, and determine whether or not health insurance was offered to employees at the establishments during the prior calendar year. If the employer did not offer health insurance in the previous year, a brief set of questions about establishment characteristics is asked and the case is considered a complete respondent. If the employer did offer health insurance in the previous year, several brief questions are asked and the employer is mailed a MEPS-IC questionnaire. Follow-up mailings, telephone calls and Computer-Assisted Telephone Interviewing (CATI) technology are used to increase response rate.

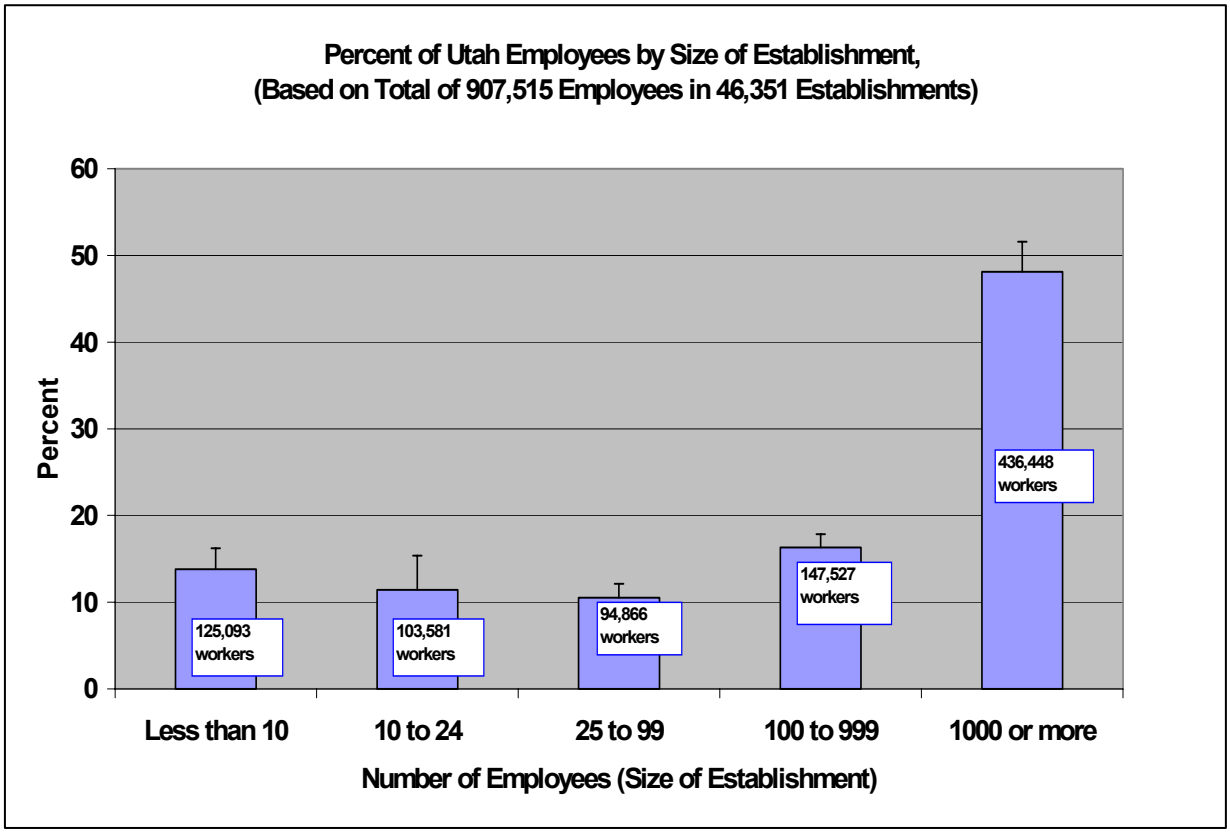
The most current information available is from the 2000 and 2001 MEPS-IC Survey findings. Based on the technical information provided by the Agency for Healthcare Research and Quality (AHRQ) - the Center for Cost and Financing Studies - statistics for more than 46,000 private-sector establishments were represented in the 2000 and 2001 MEPS-IC Survey results, reflecting the employment conditions of more than 900,000 Utahns. 14% of Utah businesses surveyed were in agriculture, fish, forestry and construction, 4.2% were in mining and manufacturing, 22.1% were in professional services, and 40.3% were in retail or other services. Other types of industries were included as an “other” group, comprising 19.4% of the sample.

Utah Employer Survey

In order to evaluate regional differences in Utah's Employer-Sponsored Insurance (ESI) and obtain more specific information on employer experiences, attitudes and opinions regarding ESI, the 2001 Utah Employer Survey (UES) was conducted. A private public opinion and marketing research company was engaged for this purpose. The State Planning Grant (SPG) staff worked closely with the contractor to develop a survey based on best practices from national employer surveys, reflecting the following goals:

• Provide baseline data for evaluating the effects of health policy changes on Utah employers' decisions to participate in health benefits programs for their employees.
• Describe the employment-based health insurance system in Utah, including the decision process, and circumstances surrounding willingness of employers to participate in health benefits for their employees.
• Identify factors (e.g., company size, industry type) that distinguish Utah employers who participate in employer-sponsored health benefits programs for their employees from those who do not.
• Identify obstacles to Utah employers who want to participate in employer-sponsored health benefits programs for their employees but have been unable to do so under existing conditions.
• Identify potential incentives to participate in health benefit plans for employees among Utah employers who do offer and are not considering offering health benefits.

Employee per employer and total employees for the state of Utah are as follows:



The sampling frame for the UES was a list, from the Department of Workforce Services and Economic Development, representing approximately 65,000 businesses. A random sample of 350 businesses representing groups of 1-9 employees, 10-49 employees, and 50-99 employees, as well as 250 businesses representing more than 100 employees were selected for a total of 1300 mailed surveys. Each survey group was equally divided among urban and rural businesses. Surveys returned for undeliverable addresses were resolved or replaced according to the sampling scheme. The survey contractor received 420 usable returned surveys (32.2% response rate) and the item responses were recorded in SPSS format. Surveys were deemed "unusable" for the study if more than 20% of the items were left blank or if the nominal question regarding health insurance was unanswered. The following is a representation of the 420 returned surveys:

Utah Employer Survey Response Profile

Business Location

Rural = 214 (51%) **Response Rate = 32.9%**	**Urban = 206 (49%)** **Response Rate = 31.7%**

Size of Business	Number of Businesses	% of Sample
0 Employees*	16	3.8
1 to 9 employees	130	31.0
10 to 49 employees	104	24.8
50 to 99 employees	75	17.8
> 100 employees	95	22.6

**As reported in returned survey. Follow-up phone calls suggested these responses represented self-employed individuals.*

Location of Business by Size of Business	Rural	Urban
0 Employees*	5 (1.2%)	11 (2.4%)
1 to 9 employees	64 (15.2%)	66 (15.7%)
10 to 49 employees	55 (13.1%)	49 (11.7%)
50 to 99 employees	38 (9.1%)	37 (8.9%)
> 100 employees	48 (11.4%)	47 (11.3%)

Percent of total sample (n=420) indicated in parentheses.

**As reported in returned survey. Follow-up phone calls suggested* these responses represented self-employed individuals.

Industry	Number of Businesses	% of Sample
Service	108	25.7
Retail/Trade	56	13.3
Wholesale/Trade	15	3.6
Financial	10	2.4
Construction	43	10.2
Manufacturing	66	15.7
Minerals	12	2.9
Transportation	8	1.9
Agriculture	6	1.4
Other	93	22.1
No Response	3	0.8

The Census-based MEPS-IC indicated that 54% of Utah businesses offer some form of health insurance to their employees. The Utah Employer Survey received 345 of 420 surveys (82.1%) from employers who indicated that their business offers health benefits to their employees. Clearly, the smaller Utah Employer Survey was more likely to be completed by employers who offer health benefits than by those who do not. Therefore, responses from the Utah Employer Survey are reported as percentages of the *biased* sample of returned surveys and generalizations should be limited accordingly.

Utah Employer Discrete Choice Survey

The SPG Staff and Memetrics, Pty, Ltd. also conducted a Discrete Choice Survey (DCS) of individuals and employers to gauge enthusiasm for various health coverage options under consideration. DCS uses advanced modeling techniques to provide a better understanding of the values and preferences of a target population. This research method employs sophisticated mathematics, theories in human choice behavior, and scientific design technologies. It involves collecting data from a carefully controlled sample to examine the influence that various factors have on the choices people make. The information is then used to build simulations that identify target groups who react differently to changes in various insurance product packages and predict how changes in key factors (i.e. benefit packages, cost sharing, provider availability, etc.) will influence future choices (uptake rates).

The target population for this survey was small and medium-sized Utah businesses who may or may not currently offer insurance to their employees. For each company, the survey respondent was the individual who made decisions regarding what or whether health coverage was offered to employees. From the total sample provided, 1,665 companies were randomly selected from the list of qualified companies to receive surveys. Qualifications included: 1) small to medium sized, 2) retail, service or industrial business, 3) available Utah address and phone contact information, and 4) not in health care, insurance, or public service sectors. From these 165 companies, follow up calls identified 342 that were not legitimate recruits (wrong business, wrong number or not in service, etc). From the remaining recruits (1,323), 209 surveys were returned for an effective response rate of 16%. After data cleaning, 154 surveys were retained for modeling (the remaining were excluded for missing or invalid data). Each of these 154 provided eight data points resulting in an effective sample size of 1,232 for modeling purposes.

The segments included in the analysis and modeling are described in the table below. The response rates were very similar across all segments with medium-sized businesses showing a slightly higher response rate than small businesses. Retained surveys are the number of respondents' surveys retained for analysis after data cleaning. Data Points are eight times the number of retained surveys as each survey included eight choice scenarios. Each choice represents a data point for the modeling analysis.

Segment Contributions to the Discrete Choice Survey

Segment	Retained Surveys	Data Points
Urban (tagged)	84	672
Rural (tagged)	70	560
Small Businesses (tagged)	61	488
Medium Businesses (tagged)	93	744
Retail/Service (tagged)	76	608
Industrial (tagged)	78	624
Does Not Offer Insurance	81	648
Offers Insurance	73	584
Average Employee Wage <= $10	75	600
Average Employee Wage > $10	75	600
Total (after data cleaning)	154	1232

The product packages for employers (included in the Discrete Choice Survey) described proposals for providing health insurance to employees and their families. Respondents were asked to choose among various health insurance options with varying levels of benefit and cost attributes. Plans were presented with various combinations of the following attribute levels:

Future Health Plans **Primary Care Network (for individuals only)**
Waiver Plan (Children's Health Insurance Program Buy-in Plan offered to parents)
Employer Cost-Sharing Plan (offered to all employees)

Additional Options
Standard Health Plan (Current plan or other known commercial plan)
No Plan (Employer would not offer coverage under the available options)

Plan Attributes and Levels	Primary Care Network	Waiver Plan	Cost Sharing Plan
Availability	Available	Available	Available
	Not Available	Not Available	Not Available
Benefit Coverage			
Primary Care…	Included	Included	Included
Catastrophic Coverage…	----	Included	Included
Specialist Services…	----	Included	Included
Extra Benefits…	Pharmacy ($5 co-pay)	Pharmacy ($5 co-pay)	Pharmacy ($5 co-pay)
	----	Limited Dental	----
	----	----	----
	----	----	----
Primary Care…	Included	Included	Included
Catastrophic Coverage…	Included	Included	Included
Specialist Services…	----	Included	Included
Extra Benefits…	Pharmacy ($5 co-pay)	Pharmacy ($5 co-pay)	Pharmacy ($5 co-pay)
	----	Limited Dental	Limited Dental ($15 co-pay)
	----	Hearing & Vision	----
	----	----	----
Primary Care…	Included	Included	Included
Catastrophic Coverage…	----	Included	Included
Specialist Services…	Included	Included	Included
Extra Benefits…	Pharmacy ($5 co-pay)	Pharmacy ($5 co-pay)	Pharmacy ($5 co-pay)
	----	Limited Dental	----
	----	----	----
	----	Mental Health Care	Mental Health ($20 co-pay)
Primary Care…	Primary Care	Included	Included
Catastrophic Coverage…	Catastrophic Coverage	Included	Included
Specialist Services…	Specialist Services	Included	Included
Extra Benefits…	Pharmacy ($5 co-pay)	Pharmacy ($5 co-pay)	Pharmacy ($5 co-pay)
	----	Limited Dental	Limited Dental ($15 co-pay)
	----	Hearing & Vision	----
	----	Mental Health Care	Mental Health ($20 co-pay)
Where you Go to Get Care	Community Health Center	Approved Providers	Community Health Center
	Approved Providers		Approved Providers
Annual Fee	You pay $0 per year	n/a	n/a
	You pay $20 per year		
	You pay $40 per year		
	You pay $60 per year		
Monthly Premium	n/a	You pay $45	You pay $25 per month
		You pay $60	You pay $35 per month
		You pay $75	You pay $45 per month
		You pay $90	You pay $55 per month
		You pay $0 (employer pays)	
Cost for Outpatient Doctor Visit	You pay $1 per visit	You pay $5 per visit	You pay $5 per visit
	You pay $5 per visit	You pay $10 per visit	You pay $10 per visit
	You pay $10 per visit	You pay $15 per visit	You pay $15 per visit
	You pay $15 per visit	You pay $20 per visit	You pay $20 per visit
Cost for Inpatient Hospital Care	n/a	You pay 30% Plan pays 70%	You pay $50
		You pay 20% Plan pays 80%	You pay $300
		You pay 10% Plan pays 90%	You pay 20% Plan pays 80%
		You pay 0% Plan pays 100%	You pay 10% Plan pays 90%

The full set of alternatives was shown to respondents earning up to 200% of the Federal Poverty Level (FPL). Those earning between 200% and 300% FPL were only shown variations of the Cost-Sharing Plan. Employers were provided with the option to choose from Waiver and Cost-Sharing Plans. They were not given the option to offer the Primary Care Network (PCN) Plan as

this is offered to individuals directly. However, half of the surveys included a description of PCN to determine if offering PCN would impact employers' decisions about whether or not to offer health care coverage benefits.

The purpose of this DCS project was to help Utah identify key factors affecting the decision to take up a specific benefit package across a range of price points. These findings may also be used to guide the development of proposals and recommendations designed to minimize "crowd-out" by identifying how employers might "choose" between their present coverage and several proposed options as public programs are expanded.

Key Informant Interviews

Finally, key informant interviews (KII) were conducted with 6 individuals representing employee benefits. Insurance planners were chosen from a group of individuals listed by the Utah Health Insurance Association (UHIA) as experts in the areas of small group health insurance plans. Each informant received the following list of issues for inclusion in the interview. One- to one-and-one-half hour face-to-face interviews were conducted.

• How adequate are existing insurance products for persons (employers) of different income levels (business types, needs)? How do you define adequate?
• What is the variation in benefits among non-group, small group, large group, and self-funded plans?
• How prevalent are self-funded employee health plans in Utah? What impact do you see this having on the State's health insurance marketplace?
• How do you think utilization would change with universal coverage?
• In your experience, what influences an employer's decision about whether or not to offer coverage? What are primary reasons employers give for electing not to provide coverage?
• What do you think the response of employers will be over the next year — to the economy, to rising costs, etc? What has been your experience in this regard since 9/11?
• Which employer and employee groups are most susceptible to crowd out by public programs?
• How do you think employers will be influenced by tax incentives, subsidies, etc? What alternatives might motivate more employers toward providing health benefits to employees?
• Do you know of insurance products that meet the intent of HB122? Do you think employers will purchase this type of product?
• How available and how popular are catastrophic coverage-only policies?
• What is an adequate, bare-bones package?

Utah Employer Survey

Owners of Utah businesses were asked to indicate whether they "strongly agree," "somewhat agree," "unsure," "somewhat disagree" or "strongly disagree" with the following statements. For brevity, the table provides a comparison of the percentage that "strongly" or "somewhat agree" with the statement by whether or not their company provides health benefits.

	Offer Health Benefits	Do not Offer Health Benefits
Providing health insurance to more Utahns would make financial sense overall.	**57.8**	**54.7**
Businesses pay in other ways if they don't provide healthcare coverage for their employees.	**56.6**	**34.7**
Employees see healthcare coverage as part of their compensation.	**68.4**	**61.3**
Uninsured workers get the same quality of healthcare as those with healthcare coverage.	**31.5**	**30.6**
The benefits of early intervention and better management of chronic and acute health problems outweigh the costs of health insurance.	**69.8**	**62.7**
In general, health insurance is not a good value for what it costs.	**47.4**	**64.0**
Workers without healthcare coverage have more absenteeism and are less productive than those who have health care coverage.	**13.2**	**5.3**
Hospital bills are inflated to pay for those who do not have insurance.	**79.0**	**62.7**
The uninsured use the ER twice as much as insured individuals.	**29.0**	**26.7**
Money spent on health coverage for employees reduces other costs.	**30.3**	**10.6**
Basic only health care coverage is no better than being uninsured.	**18.5**	**29.3**
Employers would be more likely to offer employee health benefits if they had some control over costs.	**72.4**	**82.7**

(Utah Employer Survey, 2001)

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

Firms that offer coverage tend to be larger (>50 employees – 97.8%), involved in mining and manufacturing industries (84.4%), and employ at least 75% of their workforce full time (65.8%). Firms that tend not to offer coverage are smaller (<50 employees – 39.6%), involved in agriculture and construction industries (33.6%), employ less than 50% of their workforce full time (34.2%). Overall, 54% of Utah businesses offer health benefits to some portion of their employees. *(MEPS-IC, 2000)*

Size of Business	Number of Businesses	Number of workers Represented	% Offer Health Insurance	Number of Workers Offered Health Insurance at Work
< 10 Employees	25,543 (2,229)	125,093 (18,523)	27.3 (2.68)	46,910
10 – 24 Employees	6,917 (2,204)	103,581 (50,037)*	74.8 (6.56)	85,144
25 – 99 Employees	3,360 (303)	94,866 (8,761)	83.0 (5.20)	80,731
100 – 999 Employees	2,835 (292)	147,527 (22,120)	96.4 (2.62)	147,084
>1000 Employees	7696 (1,242)	436,448 (64,100)	100 (0.00)	436,448
< 50 Employees	34,340 (2,771)	276,357 (48,485)	39.6 (3.34)	169,960
50 or more Employees	12,011 (1,454)	631,158 (83,616)	97.8 (1.63)	626,109
Industry				
Agriculture, Fishing,				
Forestry, Construction	6,511 (530)	73,337 (17,168)	33.6 (6.03)	58,450
Mining and				
Manufacturing	1,950 (322)	146,950 (24,279)	84.4 (6.04)	145,336
Retail, Other				
Services	18,682 (2,409)	359,654 (63,728)	56.7 (4.77)	259,438
Professional				
Services	10,255 (1,733)	193,419 (40,795)	48.8 (7.28)	176,592
All others	8,983 (1,133)	164,155 (39,979)	66.2 (4.13)	156,604
Average Wage				
50% or more low wage	15,299	199,079 (42,901)	44.3 (4.57)	130,198
< 50% low wage	23,515	402,767 (50,473)	52.8 (3.51)	366,155
Unknown status	7,538	305,669 (51,509)	81.9 (7.23)	299,861
Employment Status				
< 50% full time	13,144 (2,365)	173,153 (51,539)	34.2 (6.32)	126,055
50 to 74% full time	7,610 (823)	131,447 (23,372)	52.7 (5.48)	96,241
75% or more full time	25,597 (1670)	602,886 (72,853)	65.8 (3.17)	573,947

MEPS-IC, 2000

*Standard error values are displayed in parentheses. *Denotes less than acceptable statistical reliability of the estimates.*

2.1a Cost of Policies

Premium costs vary most by group size and type of provider. Those with fewer than 50 employees average $2767 annually, while those with 50 or more employees average $2552 annually for single coverage. "Any provider" policies have higher annual premiums ($2835 average) than "mixed provider" ($2632 average) or "exclusive provider" policies ($2382 average). The cost of employer-sponsored family coverage tends to vary less systematically, with the overall average at about $6069 annually. (MEPS-IC, 2000)

Policy Costs - Single Coverage

Size of Business	Exclusive Provider	Mixed Provider	Any Provider	Overall Average
< 10 Employees	$2644 (671)	$2605 (515)	$2832 (812)	$2641 (301)
10 – 24 Employees	$3341 (680)	$2902 (452)	$3126 (822)	$3113 (229)
25 – 99 Employees	$1952 (300)	$2578 (129)	$2320 (523)	$2340 (84)
100 – 999 Employees	$1881 (252)	$2374 (83)	$2573 (719)	$2262 (80)
>1000 Employees	$2090 (110)	$2699 (340)	$3326 (618)	$2674 (257)
< 50 Employees	$2611 (362)	$2836 (334)	$2580 (673)	$2767 (185)
50 or more Employees	$2041 (92)	$3019 (247)	$3272 (407)	$2552 (194)
Industry				
Agriculture, Fishing,				
Forestry, Construction	$3041 (743)	$2864 (440)	$2898 (728)	$2884 (412)
Mining and Manufacturing	$1979 (248)	$2311 (249)	$3084 (752)	$2237 (152)
Retail, Other Services	$2621 (172)	$2852 (403)	$4351 (966)	$3091 (343)
Professional Services	$1991 (165)	$2496 (164)	$2293 (684)	$2272 (85)
All others	$2168 (279)	$2562 (152)	$2329 (578)	$2451 (83)
Average Wage				
50% or more low wage	$3163 (646)	$2471 (238)	$2341 (420)	$2635 (184)
< 50% low wage	$2004 (116)	$2460 (63)	$3222 (445)	$2350 (75)
Unknown status	$2213 (134)	$2808 (419)	$3333 (585)	$2811 (333)
Employment status				
< 50% full time	$2118 (411)	$2871 (258)	$3047 (861)	$2820 (246)
50 to 74% full time	$2498 (432)	$2384 (330)	$4591 (1246)	$3047 (279)
75% or more full time	$2132 (100)	$2613 (226)	$2919 (377)	$2522 (186)

MEPS-IC, 2000

Policy Costs – Family Coverage

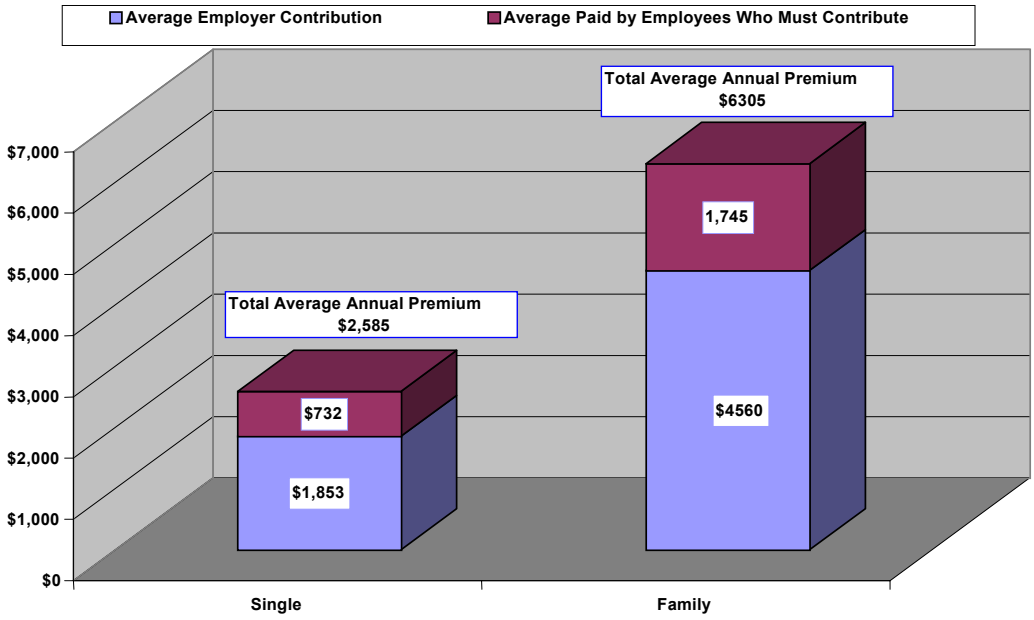
Size of Business	Exclusive Provider	Mixed Provider	Any Provider	Overall Average
< 10 Employees	$5254 (792)	$6582 (495)	$6946 (1666)	$6314 (310)
10 – 24 Employees	$7703 (1779)	$4707 (796)	$6662 (1353)	$5362 (578)
25 – 99 Employees	$5573 (717)	$5588 (210)	$5848 (1448)	$5613 (292)
100 – 999 Employees	$5693 (761)	$5881 (218)	$7199 (2148)	$5874 (191)
>1000 Employees	$5794 (463)	$7220 (540)	$6688 (1072)	$6665 (374)
< 50 Employees	$6063 (485)	$5398 (380)	$7169 (941)	$5696 (274)
50 or more Employees	$5761 (218)	$6743 (422)	$6608 (806)	$6441 (279)
Industry				
Agriculture, Fishing,				
Forestry, Construction	$6492 (1427)	$4908 (614)	$4564 (1361)	$4968 (614)
Mining and Manufacturing	$5865 (680)	$7892 (722)	$8656 (2130)	$7192 (550)
Retail, Other Services	$6139 (605)	$5861 (244)	$5331 (1190)	$5816 (162)
Professional Services	$5475 (531)	$6163 (403)	$8800 (1895)	$5982 (346)
All others	$5937 (943)	$6796 (334)	$6759 (1606)	$6644 (248)
Average Wage				
50% or more low wage	$7887 (1717)	$4627 (615)	$6540 (1389)	$5260 (556)
< 50% low wage	$5469 (301)	$6735 (382)	$8114 (1061)	$6499 (230)
Unknown status	$6033 (543)	$6465 (501)	$6152 (1159)	$6243 (402)
Employment Status				
< 50% full time	$5981 (1671)	$4640 (756)	$6265 (1497)	$4751 (537)
50 to 74% full time	$5261 (1393)	$6587 (340)	$6246 (1133)	$6123 (524)
75% or more full time	$6900 (844)	$6597 (413)	$5756 (168)	$6412 (252)

MEPS-IC, 2000

2.1b Level of contribution

On average, enrolled employees contribute an average of 22.5% of the premium for single coverage and 22.9% of the premium toward family coverage in employer-sponsored plans. Approximately one half (49.8%) of the establishments in Utah that offer health insurance offer at least one health insurance plan that requires no employee contribution for single coverage. Most of the "no employee contribution for single coverage" employer-sponsored plans were "mixed provider" plans (33.0%), with "exclusive provider" plans (11.9%) and "any provider" plans (7.3%) constituting the rest. Of the establishments offering family health policies to their employees, 25.6% offer at least one plan that requires no contribution from the employee. The distribution of "mixed," "exclusive," and "any-provider" policies in this category was similar to that for single coverage (14.6%, 7.3%, and 4.3%, respectively).

Cost Sharing Among Utah Employers and Employees for Single and Family Coverage



When business owners were asked what percent of the insurance premium should be paid for by employers and what percent should be paid for by employees, 90.6% of those who offer health insurance benefits indicated that **no more than half** of the premium should be paid for by the individual, and that half or more than half the premium should be paid for by the employer.

Among business owners who do not offer insurance, 44.3% indicated that **more than half** the premium should be paid for by the employee, while 48.6 % indicated that half or less than half the premium should be paid for by the employer. *(Utah Employer Survey)*

Employer-Sponsored Coverage:
Percent of the total premium provided by the employee

Business Size	Single Coverage	Family Coverage
< 50 Employees	12.8 (2.3)	26.1 (2.3)
50 or more Employees	24.3 (3.0)	22.3 (2.9)
Industry Type		
Agriculture, Fishing,		
Forestry, Construction	14.2 (3.7)	16.3 (5.5)
Mining and Manufacturing	17.1 (2.3)	16.2 (2.5)
Retail, Other Services	28.1 (6.4)	30.5 (6.3)
Professional Services	19.0 (2.0)	24.0 (2.5)
All others	22.9 (2.4)	25.9 (4.3)
Employee Wage		
50% or more low wage	38.3 (7.8)	35.6 (6.2)
< 50% low wage	19.6 (2.5)	21.1 (2.3)
Unknown status	22.7 (4.6)	23.4 (2.9)
Employment Status		
< 50% full time	18.3 (4.6)	23.8 (6.1)
50 to 74% full time	19.6 (7.2)	24.3 (5.7)
75% or more full time	23.4 (2.8)	22.8 (1.9)

MEPS-IC, 2000

2.1c Percentage of employees who are eligible for employer-sponsored health coverage who participate.

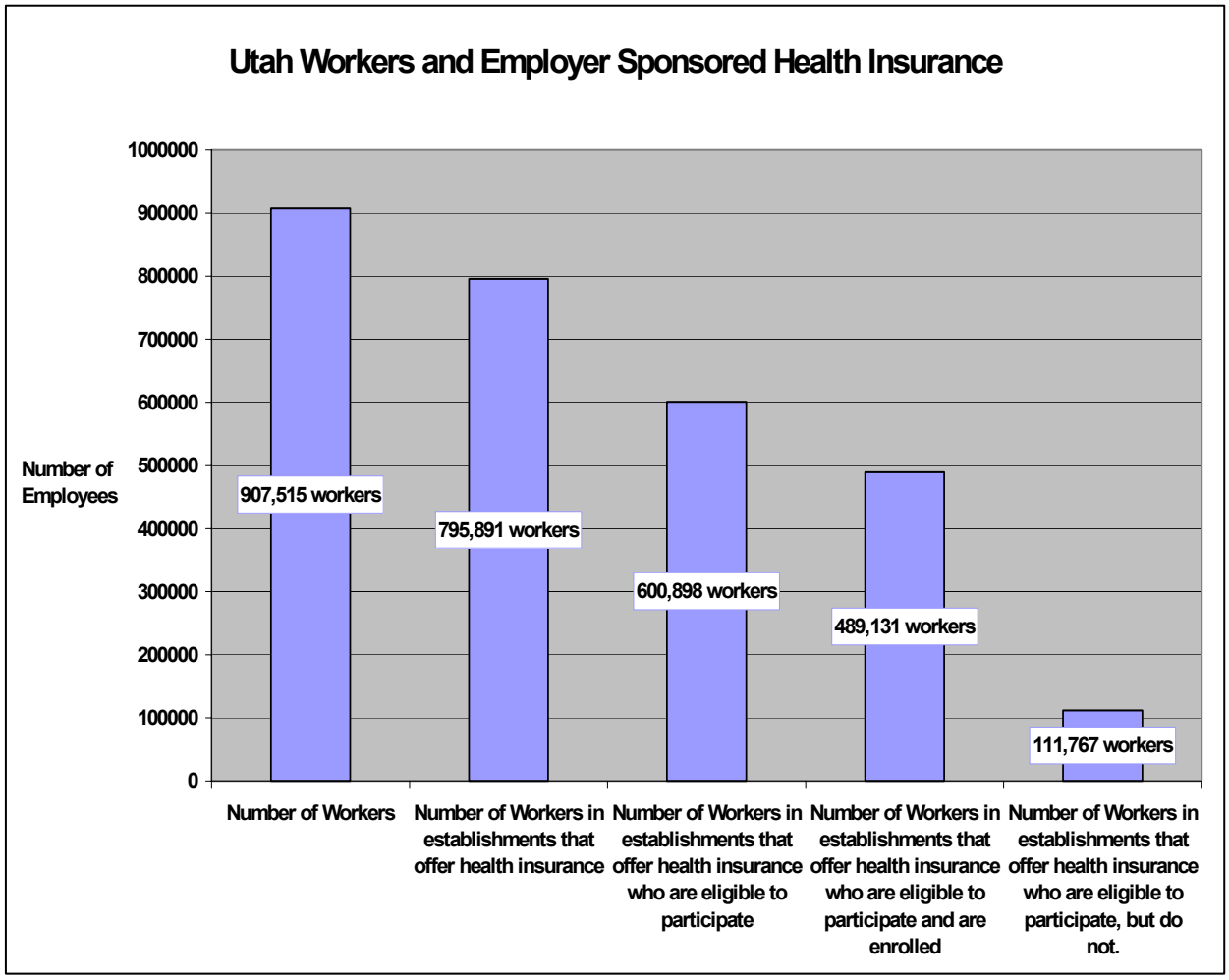
Overall, 54% of Utah businesses offer health benefits to some portion of their employees. (MEPS-IC, 2000) For companies with more than 50 employees and less than 50% with low wages, approximately 80% of these employees, eligible for coverage, participate in an employer-sponsored health plan. However, individuals who work in smaller businesses (<25 employees, 50.3%) and those who work in businesses where more than 50% of the employees are paid low wages (32.5%) are most likely to be eligible but not enrolled in employer sponsored coverage.

Even for business categories with low eligible-to-enrolled ratios, the *number* of individuals who decline employer-sponsored health insurance can be impressive.

Eligible Workers Enrolled in Employer-Sponsored Health Coverage

Business Size:	Number of Workers Represented	Percent of Workers Eligible for Employer-Sponsored Health Coverage	Percent of Eligible Workers Enrolled	Percent of Eligible Workers Not Enrolled	Number of Workers Eligible But Not Enrolled
< 10 Employees	46,910	72.9 (3.52)	77.6 (5.02)	22.4	7,660
10 – 24 Employees	85,144	48.6 (11.71)	82.1 (4.36)	17.9	7,407
25 – 99 Employees	80,731	74.1 (5.22)	73.4 (3.37)	26.6	15,913
100 – 999 Employees	147,084	75.1 (4.39)	83.6 (2.13)	16.4	18,115
>1000 Employees	436,448	81.5 (3.91)	82.3 (2.04)	17.7	62,960
< 50 Employees	169,960	62.9 (6.13)	78.2 (3.76)	21.8	23,305
50 or more Employees	626,109	79.0 (2.53)	82.0 (1.71)	18	89,033
Industry Type					
Agriculture, Fishing,					
Forestry, Construction	58,450	84.9 (9.98)	81.2 (9.29)	18.8	9,329
Mining and Manufacturing	145,336	90.0 (2.15)	89.6 (2.50)	10.4	13,603
Retail, Other Services	259,438	60.9 (4.15)	75.7 (3.38)	24.3	38,393
Professional					
Professional Services	176,592	71.4 (5.70)	75.0 (3.88)	25	31,521
All others	156,604	87.7 (2.38)	85.9 (2.40)	14.1	19,365
Employee Wage					
50% or more low wage	130,198	43.4 (6.09)	67.5 (5.03)	32.5	18,364
< 50% low wage	366,155	84.6 (1.53)	79.9 (1.95)	20.1	62,263
Unknown status	299,861	74.5 (4.38)	86.6 (2.30)	13.4	29,935
Employment Status					
< 50% full time	126,055	23.5 (3.50)	77.8 (7.69)	22.2	6,576
50 to 74% full time	96,241	67.1 (3.65)	68.4 (4.12)	31.6	20,406
75% or more full time	573,947	88.4 (1.36)	83.2 (1.39)	16.8	85,238

MEPS-IC, 2000



2.2 What influences the employer's decision whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

A report from the Urban Institute concludes: "A worker's ability and willingness to pay for health insurance coverage are key to a firm's decision to sponsor a health insurance program." (Urban Institute, 8/29/01) Information from key informants (insurance planners) confirmed that in Utah, the needs and demands of employees (or potential employees who have chosen other job opportunities based on availability of health insurance), are often the primary reason an employer seeks information on health plans. One of the most pervasive motivators cited was the business

owners' personal insurance needs. Many employers find themselves unable to procure an individual or family health policy because of pre-existing illness and/or cost, and thus choose to provide a group plan for their small company.

The Utah Employer Survey netted responses from 75 business owners or partners who do not offer health insurance to their employees. The 3 top reasons for not offering health insurance include:

- Revenue is too uncertain to commit to a plan
- Employees cannot afford it
- Cost of employee benefits are difficult to control

The Utah Employer Survey included responses from 75 business owners or partners who do not offer health insurance to their employees. The following question was asked:
For each of the following, please indicate whether this is a major reason, a minor reason, or not a reason why your business does not offer health insurance.

	Major Reason	Minor Reason	Not a Reason	Unsure
Setting up a plan is too complicated and time consuming.	6.70%	32.00%	56.00%	5.30%
Revenue is too uncertain to commit to a plan.	56.00%	22.70%	14.70%	6.60%
Employees cannot afford it.	41.30%	22.70%	28.00%	8.00%
Employees are healthy and do not need it.	4.00%	14.70%	73.30%	8.00%
Employees have coverage elsewhere.	34.70%	22.70%	37.30%	5.30%
Employees prefer wages and/or other benefits.	29.30%	24.00%	38.70%	8.00%
My/our business does not need to offer health insurance in order to recruit and retain good workers.	14.70%	38.70%	40.00%	6.60%
A large portion of my/our workers are seasonal, part-time, or high turnover.	32.00%	20.00%	41.30%	6.60%
The company has had an adverse experience with employee healthcare coverage administration.	6.70%	10.70%	76.00%	6.60%
The company was denied coverage.	4.00%	9.30%	80.00%	6.60%
Don't have enough information to make a decision about benefits.	2.70%	20.00%	70.70%	6.60%
Costs of employee benefits are too difficult to control.	41.30%	21.30%	28.00%	9.30%

(Utah Employer Survey, 2001)

And, at least for these 75 businesses, health benefits are unlikely to be added under the current economy. Answers to the following question reflect this condition.

Under current economic conditions, how likely is it that your business will start a health plan for employees in the next two years?

Extremely Likely	**1.30%**
Somewhat Likely	**5.30%**
Somewhat Unlikely	**17.30%**
Not at all Likely	**57.30%**
Unsure	**18.80%**

2.3 How do employers make decisions about the health insurance they will offer to their employees? What factors go into their decisions regarding premium contributions, benefit package, and other features of the coverage?

National surveys indicate that employers make decisions primarily based on cost (81%), and expressed desires and satisfaction of the employees (45.3%). More than one-half (61.4%) of those who offer health benefits indicate that they choose among a limited number of available programs for their group, and 29.3% would be inclined to implement changes if more choice became available. *(Employee Benefit Research Institute, 2002 Benefits Survey)*

As costs continue to increase, employers are faced with constant pressures to provide employees with insurance, while keeping costs in line. A couple of ways most employers deal with cost-containing measures include: scaling back benefits, and increasing employee's portion of insurance premiums and co-payments.

2.4 What would be the likely response of employers to an economic turndown or continued increase in costs?

More than 50% (53.3%) of the business owners who returned the Utah Employer Survey indicated that they would be unlikely to terminate coverage for their employees under any circumstance. As costs continue to rise, companies are faced with increased challenges to maintain some kind of health insurance program. Because many employers who offer health insurance are not willing to eliminate coverage, many employers are considering self-funding as a potential way to control costs.

However, not every employer is willing to shoulder the bulk of the premium increases. Utah Department of Workforce Services reports that more than 32% of Utah retirees have experienced a loss of retirement health benefits or increased costs associated with group coverage under their former employer in the last year. In addition, required employee contributions have increased an average of 11%, for single coverage, and 25% for family coverage in the last year. Many employees (44.0%) have experienced reduced benefits due to changes made by employers to control costs. Clearly, employers in Utah are passing some, but not all of the increased costs on to their employees who want to maintain coverage.

2.5 What employer and employee groups are most susceptible to crowd-out?

A review of the literature suggests that the mechanisms by which crowd out may occur are not well understood. Generally, crowd out is a small to moderate factor in explaining declines in insurance coverage.

One study (Cutler and Gruber, 1996) indicates that expansions of Medicaid coverage are associated with a decline in private insurance coverage of 1.7 million persons nationwide, or 17% of the 9.9 million person decline in private insurance between 1987 and 1992. However, an investigation of whether the likelihood of a firm offering insurance is related to the share of firm employees or their dependents who are eligible for Medicaid indicated no association.

The cost of expanding public-sector health programs depends critically on the extent to which public eligibility will cover just the uninsured or will crowd out existing private insurance coverage. During the period of 1987 – 1992, Cutler and Gruber estimate the extent of crowd-out arising from the expansions of Medicaid to pregnant women and children of approximately 50 percent in Medicaid coverage was associated with a reduction in private insurance coverage. This occurred largely because employees took up employer-based insurance less frequently. There is also some evidence that employers contributed less for insurance and that workers dropped coverage of dependents.

In that study, the primary way Medicaid expansions reduced private coverage was through reduced employee take up of coverage, especially among workers in firms that had to pay toward the premium (Keenan, 2000). Another study suggests that for people with low incomes, the likelihood of having private coverage is lower, and of being uninsured is higher, in areas with a public hospital. In this case, safety net availability might be seen as contributing to crowd out.

The Primary Care Network includes a direct method for preventing traditional crowd out: Individuals who have access to health insurance through their employer or who have voluntarily terminated coverage in the last 6 months are ineligible for the program. During the first 6 months of enrollment, 5% of the total (40,213 applications) was turned down due to current enrollment in other insurance. Another 4% was denied eligibility due to their access to other insurance and 50 individuals (< 1%) had voluntarily terminated insurance in the previous 180 days.

Information from the decision support system from the Discrete Choice Survey results suggested that the pattern of switching to the PCN plan from other plans appeared weak. In fact, offering the PCN plan as a point of comparison made a cost-sharing plan look more attractive. When the PCN was available as an option, more customers switched from none (their current situation of having no or traditional insurance) to an Employer Cost-Sharing Plan than when PCN was not listed as an alternate option. This implies that there may have been some value in offering and marketing the PCN option as a base plan both to attract particularly underserved markets and to attract demand to another plan with higher benefits and moderate costs.

2.6 How likely are employers who do not offer coverage to be influenced by tax incentives, or premium subsidies?

The Utah Employer Survey results indicate that, of the 74 businesses surveyed, 57.3% that do not offer health insurance benefits are "Not at all likely" to start a health plan in the next two years. Only 6.6% are "extremely or somewhat likely" to do so, 17.3% are "somewhat unlikely" to do so and 18.7% are "unsure." Potential influence of purchasing alliances, subsidies, and tax incentives were specifically addressed in planning workgroups.

Under current economic conditions, how likely is it that your business will start a health plan for employees in the next two years?

Extremely Likely	**1.30%**
Somewhat Likely	**5.30%**
Somewhat Unlikely	**17.30%**
Not at all Likely	**57.30%**
Unsure	**18.80%**

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

Only 14.7% of the businesses who do not currently offer health benefits indicated that uncertain revenue was not a reason why they did not offer employee health insurance. On the other hand, 62.6% indicated that the costs of employee benefits are too difficult to control, and 53.4% indicated that their business did not need to offer health insurance in order to recruit and retain good workers. The most promising motivators for Utah businesses who do not currently offer health insurance are likely to include an upturn in the economy and a downturn in unemployment rates.

Although availability of adequate revenue and competition for a good, steady workforce have a strong influence on employer decisions, employee variables are also important; 64.0% of those not offering insurance reported that their employees lack of ability to afford the premiums or their preference for wages and other benefits (53.3%), or the fact that employees had coverage elsewhere (spouses, 57.4%) constituted a major or at least minor reason why they did not offer health insurance. Overall, as the economy declines, benefits decline. As the economy improves, companies usually increase benefits, but at a slower pace than that at which the economy recovers.

"If the federal or state government wants to increase health insurance coverage, then they should go through the employers and the businesses. The incentive should be toward increasing employer-sponsored coverage, and making it easier for employees to cover their families through their jobs. It doesn't make sense to offer individual incentives, the payoff isn't immediate enough and the individual market doesn't have the benefits. Market forces come into play for the group policies. Employers should also set up 125K plans for their employees and educate them on the costs, value, purpose of health insurance and the advantages that a 125K account has. In fact the flexible spending accounts are the best instrument we have for using money that would go to the government to pay for health care. People just have to be shown the tradeoffs and they would always choose to spend through 125K. And for employers, it offloads the burden to the government … the numbers pan out." *(Key Informant Interview, May 2003)*

Section 3. Summary of Findings: Health Care Marketplace

According to the Utah Department of Insurance 2003 Health Insurance Market Share Report, http://www.insurance.state.ut.us/2003HealthInsRpt.pdf, 1,451 commercial insurance companies were operating in Utah during 2002. Of these, 388 reported health insurance-related business in Utah. Overall, 61% of the health coverage policies in Utah were comprehensive health insurance, 11% were Federal Employee Health Benefit Plans, and 8% were Medicaid. The comprehensive health insurance market serves approximately 39.4% of Utah residents. The most common type of plan is administered by a domestic health insurer, through an employee group policy with an HMO-style plan.

Residents of Utah procure their health insurance from three sources: Government (14%), employer-sponsored self-funded plans (34%), and commercial health insurance plans (35%). The rest are uninsured (9%) or status unknown (8%). Each of the major sources of health insurance is regulated by a different set of laws and government agencies. Public (government) insurance is regulated by Federal agencies (e.g., Centers for Medicare and Medicaid Services, CMS), employer-sponsored self-funded health insurance is regulated by the Department of Labor, CMS and the Internal Revenue Service under the Federal ERISA statute, and commercially sold health insurance is regulated by state insurance departments.

Among commercial insurers in Utah there is a broad universe of health insurance products. These may include comprehensive health insurance, long term care, dental, vision, disability, accident, specific diseases, or may exist as supplemental to other kinds of benefit plans. Utah's commercial health insurance market is highly concentrated among eight health insurers, representing over 83.4% of the market. Nearly 78% of Utah's health insurance providers have their home office in Utah State and, for these 26 insurers, 70% of their total revenue comes from Utah business. Overall, eight health insurers represent nearly 70.2% of Utah's domestic market.

2002 Utah Group Policy Market Share Report

Company Name	Market Share	Direct Premiums Earned
IHC Health Plans Inc.	35.90%	$532,464,456
Regence BC/BS of Utah	18.80%	$278,793,166
Altius Health Plans	11.51%	$170,713,572
United HealthCare of Utah	7.48%	$110,953,422
United Healthcare Ins Co	3.34%	$49,579,540
Educators Mutual Ins Assoc	3.04%	$45,138,592
Healthwise	1.76%	$26,089,455
Ace American Ins Co	1.54%	$22,869,078
Total for top 8 ranked insurers	83.37%	$1,238,601,281
Total for all 240 insurers writing this line	100.00%	$1,483,215,624

2002 Utah Individual Policy Market Share Report

Company Name	Market Share	Direct Premiums Earned
IHC Health Plans Inc.	28.31%	$59,432,809
Regence BC/BS of Utah	22.01%	$46,214,503
American Family Life Asr Co Columbus	6.47%	$13,580,067
United American Ins Co	3.78%	$7,929,276
Mutual of Omaha	3.20%	$6,726,796
Equitable Life and Casualty Ins Co	3.04%	$5,375,893
Sterling Life Ins Co	2.56%	$4,031,577
Bankers Life and Cas Co	1.92%	$4,008,920
Total for top 8 ranked insurers	70.16%	$147,299,841
Total for all 274 insurers writing this line	100.00%	$209,923,692

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?

Like the state of Texas, Utah did not attempt to collect specific data on the adequacy of existing insurance through survey activities or focus group sessions. However, the issue of adequacy of coverage was discussed in general at every key informant interview and during most focus group sessions. Utah's findings were very similar to the Texas Focus Group findings. Focus group participants in particular expressed frustration with the lack of affordable coverage for individuals with pre-existing health conditions. While many focus group participants were aware of the availability of coverage for individuals with pre-existing conditions, they found the premiums to be unaffordable and felt their experience was fairly typical of many uninsured Utahns.

Through survey activities and focus group sessions, Utah defines "adequate" in the following ways:

"Something that covers a patient's basic needs." – *Clinic Manager*

"Where the patient feels responsible for his/her own general health care costs – and are disinclined to overuse the system – but feels protected from catastrophic loss. There should be a way to 'incentivize' the individual to maintain their health through insurance cost-sharing requirements. The coverage would be dumbbell-shaped, where the insurance plan would provide high coverage for preventive and catastrophic care, and the individual would be responsible for care in-between." – *Hospital CEO*

"Insurance which enables you to be financially solvent. It prevents financial devastation."- Utah Legislator

"Historically, insurance has been for catastrophic needs. I think our society now would define adequate coverage as being for preventive maintenance. Catastrophic illness and any type of coverage that would help them to maintain a healthy lifestyle." – *Clinic Manager*

The following table indicates Utah's estimate of health insurance coverage for 2002

Coverage Type	Population Estimate	Percent of Population
Government Sponsored Plans (CMS Regulated)	400,590	17.13%
Medicaid	154,784	6.62%
Medicare	214,507	9.17%
State Health Insurance Pool (HIP)	2,347	.10%
Children's Health Insurance Program	24,505	1.05%
Utah Medical Assistance Program (Now part of PCN)	4,447	.19%
Employer Sponsored Self-Funded Plans (ERISA Regulated)	922,006	39.42%
Plans Administered by Commercial Insurers	420,480	17.98%
Public Employee Health Program (PEHP)	142,972	6.11%
Federal Employee Health Benefit Plan (FEHBP)	68,373	2.92%
Other Known Self-Funded Plans	44,483	1.90%
Other (estimated) Self-Funded Plans	245,698	10.51%
Commercial Health Insurance Plans (State Regulated)	813,394	34.78%
Group	684,673	29.28%
Individual	128,721	5.50%.
Uninsured	202,771	8.67%
Total	**2,338,761**	**100.00%**

Utah Department of Insurance, Utah Health Insurance Market report 2002

Individual policies generally provide fewer benefits compared to group plans, require higher out-of-pocket expenses, and often exclude coverage that individuals with pre-existing health problems are likely to need. Utah's low income advocacy groups and many individual focus group participants also expressed particular concern over the lack of coverage for mental health treatment and prescription drugs in many of the available individual plans.

Utah has implemented a program called the Primary Care Network (PCN) for the "working poor" to obtain affordable and adequate coverage; however, the PCN does not cover specialty care and inpatient hospital visits. Those without insurance or public coverage, primarily rely on the safety net or public assistance for healthcare options.

3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans?

Total 2001 Comprehensive Market by Group Size

Group Size	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM*
Total Individual	71	112,434	$130,155,593	9.94%	79.04	$97
Individual	64	110,295	$122,678,509	9.37%	75.16	$93
Conversion	17	2,139	$7,477,084	0.57%	142.64	$272
Total Group	57	742,584	$1,178,682,042	90.06%	85.72	$126
Small Group (2-50)	39	208,100	$317,680,953	24.27%	78.45	$119
Large Group (50+)	37	534,484	$861,001,089	65.78%	88.41%	$129
Total Comprehensive	**103**	**855,018**	**$1,308,837,635**	**100.00%**	**85.06**	**$123**

Source: 2001 Utah Accident and Health Survey
* Direct earned premium per member per month

Mirroring national trends, more than 90 percent of covered persons in Utah's comprehensive market are insured by group plans, with the remainder in individual plans. There are currently more insurers competing in the individual market than in the group market.

Group policies report higher premium per member per month ($126) than individual policies ($97). This may be due to underwriting practices. In individually underwritten policies, insurers have more ability to set rates based on health criteria. As a result, sicker individuals who would incur higher medical costs would be given policy offers with higher premiums than healthier individuals. However, less expensive policies are more likely to be accepted than expensive ones. So the individual market's lower premium may reflect the tendency for healthier individuals to get and accept more affordable health insurance coverage.

In contrast, group policies are underwritten without taking individual health status into account. Each group is a mix of healthy and sick individuals, and the larger the group the more equally distributed the mix. Thus, medical claim costs tend to be higher and policyholders are charged higher premiums to pay for these individual costs. However, group premiums tend to be less expensive for sicker individuals compared to what they would pay if they were individually underwritten.

Individual policies generally provide fewer benefits compared to group plans, require higher out-of-pocket expenses, and often exclude coverage that individuals with pre-existing health problems are likely to need.

Conversion policies had the highest premium per member per month ($272). This is probably due to the fact that conversion policies are often issued to individuals who are ill, who have more expensive medical needs, and who have a critical need to continue coverage even though their group policy is no longer available. Less than one percent of the market was insured by conversion policies.

The health benefits provided by these plans will range from comprehensive major medical benefits to single disease or accident only benefits. Information regarding the variation in benefits among different sized groups was not sought for in this report.
(Utah Health Insurance Association, 2001 Report)

3.3 How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace?

In Utah, 50.7 % of workers who are eligible and enrolled in health insurance plans at work are in self-funded plans. (MEPS-IC) Of these individuals working for companies with self-funded plans, 87.2% work at companies with more than 1000 employees. Only 3% work at companies with fewer than 100 employees. Since 1999, the number of Utah residents covered by comprehensive health insurance declined by 6.63%. One of the important factors influencing this change is the shift by large employers from commercial health insurance to employer-sponsored, self-funded health benefit plans. Many employers look at self-funding as a potential way to control costs. Based on information and opinions provided by Key Informants, an employer who finds that his or her company has paid substantially more in premiums than employees have claimed as medical expenses may be reluctant to continue subsidizing companies with less healthy employees. Although self-funding may be perceived as a way to bring costs in line with claims, companies that self-fund face substantial risk.

Self-insured employer plans provide health insurance coverage for 33.65% of Utah's residents. This may be broken down by Plans Administered by Commercial Insurers (21.35%); Public Employee Health Program (5.47%); Federal Employee Health Benefit Plan (4.91%), and other known self-funded plans (1.9%). (Utah Health Insurance Market Report, July 31, 2002.)

Since 1999, the number of health insurers providing comprehensive health insurance in Utah has declined by 19.4% (from 18 to 14 domestic companies, and from 105 to 89 foreign insurers). Several moderately-sized domestic insurers have left or are in the process of leaving the market. When asked, Utah insurers cited lack of profitability and the growing number of self-insurers as their reasons for leaving the market.

In terms of impact on the marketplace, 922,006 workers and their families were covered by self-funded employer-sponsored health insurance in 2002. This represents just over half of the individuals covered through the employer-sponsored health insurance market. These self-funded plans comprise 33.65% of the plans in Utah, compared with 37.24% commercial plans.

3.4 What impact does your State have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees)?

The State of Utah influences the purchase of health care particularly through the Public Employee Health Program (PEHP) for State employees, and through the Department of Health for Medicaid, CHIP and PCN. As of 2002, 17.13% of Utah's population (approximately 400,900 individuals) participated in Government-sponsored plans and 6.11% (142,972 individuals) were insured through PEHP.

Medicaid medical assistance expenditures comprise over 80% of the annual budget of the Utah Department of Health. As the Utah population grows, so does the number of Utahns receiving assistance from Medicaid. The increase in Medicaid enrollees combined with increases in the costs of providing health care cause the Medicaid medical assistance expenditures to rise over time.

Because of Utah's relatively healthy population, it has a lower per-capita total health care expenditure than most states (regardless of payer), and lower per-capita Medicaid expenditures than most states. Utah's per-capita Medicaid expenditures (dollars spent per state population) is second lowest in the U.S. *(Utah Public Health Outcome Measures Report, 2002)*

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

In Utah, (based on focus groups and key informant interviews) mandates and bureaucratic intervention are not strongly accepted forms of providing and accessing services of any sort. These systems are largely reliant on taxation and high regulation, place a significant emphasis on preventive care, require co-pays and ration care through waiting lists, which is not likely to succeed in the State of Utah.

Due to the conservative political environment in Utah, a single-payer system would not be feasible. Such a system would require dramatic changes in the manner that taxes and health care are currently administered.

Arizona reported that this type of system could also require mandatory employer-based coverage or taxation, more uniformity of benefits, more regulation of provider fees, and restrictions on patient choice of provider and services. All of these are unpopular in Utah. *(Arizona HRSA Final Report)*

3.6 How would universal coverage affect the financial status of health plans and providers?

The structure of any "universal coverage" proposal will determine the financial impact to health plans and providers. If the goal is to insure all of the uninsured, this plan would require leveraging existing insurers as the base, while increasing taxes and most likely offsetting costs by drawing on existing providers to help fund this "uninsured" group. Pooling the uninsured would require tax subsidies to fund this program.

In support of this program, advocates claim that a universal coverage plan for all of the uninsured would decrease insurance premiums. Decreases would be realized in the following ways: 1) current insurers could drop rates if everyone pays, 2) if everyone pays, doctors could drop their rates as well (though it is unrealistic to think they would without a mandate).

Initially, providers would benefit. Over time, reimbursement may not keep pace with costs. If reimbursement were adequate, then health plans may not see any adverse effects. If not, the health plans would likely lose.

Overall, the plan would benefit some while hurting others. Regardless of which plan was chosen, there would need to be disenrollment guidelines.

"Universal coverage takes away urgency/priority of health coverage and medical attention. Great for uninsured, bad for insured." *(VA Hospital)*

To successfully implement a universal coverage plan, Utah would need significant increases in taxes to cover the uninsured, mandatory employer-based coverage, ERISA exemption, more uniformity of benefits, more regulation of provider fees, restrictions on patient choice of provider and income-based differentiation of benefits and/or contributions.

Preliminary studies from Massachusetts and Vermont found that the financial aspect of such a system would require major overhauls to the way plans and providers currently function. Profitability of both health plans and providers would most likely be regulated in a more stringent and unacceptable manner. A significant amount of collaboration and consensus between all stakeholders in the health care system would be required. Based on the experiences of Massachusetts and Vermont, a single-payer system would be even less politically viable in Utah.

3.7 How did the planning process take safety net providers into account?

A range of safety-net providers was represented on the project steering committee and workgroups. Safety-net administrators and providers in our key informant interviews were also consulted. Their experience and advice helped us to understand how and why the uninsured seek care in the manner that they do. Their knowledge enabled us to consider proposals that would benefit our target population.

The safety net was a significant consideration with development of the PCN. Implementation of the PCN was intended to lessen the burden currently placed on safety-net providers. By providing coverage for preventive care services, the PCN compensates PCPS clinics, many of whom may be safety-net providers, and attempts to reduce ER utilization.

An assumption made was that some providers would deliver PCN services, as we planned to include them. Consideration was given to the network of safety-net providers. Commitment from high volume providers and a commitment of access from a panel of physicians was paramount in assuring success with the PCN program.

A community-wide expansion model using 1) cost-sharing model (based on the Muskegon County, Michigan model), 2) general expansion of safety-net with community-based partners, and 3) primary care model was considered. This option would use Community Health Clinics (CHC) and safety net with mobile clinics and clinics next to emergency rooms as components.

3.8 How would utilization change with universal coverage?

According to our focus groups and key informant interviews, if universal coverage were implemented there would most likely be over-utilization. Several of our interviewees already experience over-utilization from those patients who have free or low-cost coverage. Comments such as, “Medicaid patients come in for everything” echoed throughout the state. If utilization did increase, many providers would be unable to absorb the higher patient load. Several safety-net providers expressed that they are already operating at capacity.

3.9 Did you consider the experience of other States with regard to:

The project's four original workgroups were presented with a large amount of data on all aspects of other states' experience. Workgroup participants were encouraged to supplement the database with additional relevant information. Elements of programs currently being offered in other states are evident in many of the proposals presented by the workgroups to our project steering committee.

Expansion of Public Coverage: Public programs in Rhode Island, Minnesota, and Tennessee were researched. These states' programs qualify individuals at a higher than average income. Their programs serve as models to understand the implications of broader public program access.

Public/Private Partnerships: Consideration was made of Access Health of Muskegon County, Michigan, and Basic Health of Washington State. These proposals were presented to the Summit Group, and were identified as final policy options.

Incentives for Employers to Offer Coverage: Access Health of Muskegon County used some incentives to encourage employers to offer coverage. No other programs were found that had any significant incentives for employers to offer coverage that appeared viable in Utah. Utah held a two-day expert seminar to better understand this type of program.

Regulation of the Marketplace: Comparisons of health insurance benefit mandates across several states were made. Also, an evaluation was made of Hawaii's success rate at mandating higher coverage. Overall, coverage levels were not significantly higher than Utah.

Section 4. Options for Expanding Coverage

During the months of June and July of 2001, approximately 21 people who represented various sectors of the healthcare industry attended meetings to develop detailed proposals to provide access to healthcare for a significant portion of Utahns with incomes below 200% of the Federal Poverty Level (FPL). The group discussed the following issues as possibilities to consider implementing:

- First, a Community-Wide Expansion Model using 1) Cost-Sharing Model (based on the Muskegon County, Michigan model), 2) general expansion of Safety-Net with Community-Based Partners, 3) Primary Care Model. This first option would use Community Health Clinics (CHC) and safety-net with mobile clinics and clinics next to emergency rooms as components.
- Second, a Private-Employer Model – this program would use a voucher system, as well as new insurance products.
- Third, an Expansion/Buy-In Program - this particular model would provide subsidies from CHIP or Medicaid funds to buy into private employer plans.
- Finally, a Single-Payer Plan - a non-profit health insurance plan covering every Utahn for all medically-necessary services.

Community-Wide Expansion Model

Cost-Sharing Model (based on Muskegon County, Michigan model)
Hesitations to implement this program included the following:

- Enrollment for Muskegon County was slow in the beginning
- Enrollment would require the creation of a new system
- Claims are higher in the beginning than normally anticipated
- Some portions of the funding used to finance the program were not guaranteed
- Start up costs could be costly
- Added concern over accommodating particular special populations
- Finding community funding

This proposal never materialized into an actual program.
(Covering the Uninsured 2002 Meeting Minutes June 18, 2001)

Strengthening Community-Based Health Centers and the Safety Net
Program evaluators stated that although it would be easy to build on existing programs, it could serve a wide variety of special populations and very low-income people. It is difficult to raise more funding and build additional infrastructure for programs that already suffer from funding cuts and shortages. Future funding is uncertain and it is difficult to convince the legislature that funding is important. Consequently, before this proposal could materialize the UMAP program lost complete funding in 2001.
(Covering the Uninsured Meeting Minutes 2002 June 18, 2001)

Primary Care Model
Although a viable program, it would need the following elements to ensure success: 1) strengthened safety net, 2) catastrophic coverage component, and 3) employer contribution. Because future funding was uncertain and it was difficult to convince the legislature that funding was important, this proposal never materialized.

Private-Employer Model

The Private-Employer Model uses a voucher system – the same concept as the CHIP expansion with employer buy-in and cost sharing. In addition, there would be a possible avenue for catastrophic coverage to combine with PCN.

Expansion/Buy-In Program

This solution seems to include some of all of the options. When viewed as a whole, these combine to provide a broad range of coverage, which is seen as a possible next step following implementation of the PCN. Some other pieces include: 1) Section 1931 Expansion to parents, 2) CHIP Waiver to parents, 3) small business and self-employed CHIP Buy-In (same as voucher), and 4) Section 1115 Waiver (same as PCN).

Single Payer Plan (a non-profit health insurance plan covering every Utahn)

A single-payer plan would be a statewide, non-profit health insurance plan covering every Utahn for all medically-necessary services including acute, rehabilitative, long-term and home care, mental health, dental services, occupational health care, prescription drugs and supplies, and preventive care. Boards of expert and community representatives would assess which services are unnecessary or ineffective, and exclude them from coverage. Private insurance duplicating the single-payer coverage would be prescribed. Patient co-payments and deductibles would also be eliminated. The single payer proposal was a major component in the expansion options, but was never implemented into an actual program.

Cost Containment Recommendations – Prescription Drug Reform

Prescription drug costs have seen double-digit increases in recent years. Nationally, insurers predicted drug costs to rise another 19% in 2003 (KFF, December 2002). Such increases in the cost of prescription drugs are putting increased pressure on state Medicaid budgets. In Utah, the increase for the past two years has been 12% each year (FY 2002 and FY 2003). For FY 2002, Utah spent $128,250,800 on Medicaid prescription drugs, representing 12% of the total budget. In FY 2003, Utah spent $149,956,000 on Medicaid prescription drugs, which represented 13.7% of the total budget. (Medicaid Management Indicator Report)

Utah's Medicaid prescription drug program currently reimburses at Average Wholesale Price (AWP) minus 12%. Dispensing fees are $3.90 for urban areas and $4.40 for rural areas. There are no supplemental rebates in effect, so on average, Medicaid receives approximately 20-21%. It is against state law for Medicaid to have a formulary (one proposed method to reduce prescription drug costs). Utah can, however, have a preferred drug list (PDL) with non-preferred drugs on prior approval. It is not likely that Utah will implement a PDL anytime soon because state legislators have not supported the concept.

Some of Utah's barriers to containing prescription drug costs include an upper limit on co-pays, no formulary allowed, and mandated coverage of any product (with a select few exceptions) of any manufacturer that signs the federal rebate agreement.

Many states face the same barriers to containing costs and have implemented programs to overcome them. Florida is one of the most notable examples of containing prescription drug costs. They created a Medicaid preferred drug list in May 2001 via law S792. A committee appointed by the governor was formed to develop this list of drugs that Medicaid providers can prescribe to their patients without receiving prior authorization. Physicians are required to call the state and request approval for the prescription of any drug not included on the preferred drug list. The law also allows Florida Medicaid to negotiate supplemental rebates from manufacturers that want their products to be included on the list. In lieu of cash rebates, the agency may accept a manufacturer's plan to provide disease management and other services that guarantee Medicaid program savings – two manufacturers, Pfizer and Bristol-Myers Squibb (BMS), have agreed to sponsor such programs to date (KFF, Feb. 2002). Physicians are also required to seek prior authorization from the state before their patients receive a fifth or higher brand-name drug.

Florida's preferred drug list is comparable to formularies used in the private sector to contain costs. The state's anticipated savings from creating a PDL was $214 million per year, including the supplemental rebate. The Pfizer disease management initiative promises $33 million in savings over two years; the BMS initiative guarantees $16.3 million over two years. "…The four-brand limit, clinical prior authorizations, the preferred drug list and related initiatives – have saved the agency $500 million." (Florida Medicaid Website)

In August of 2001, the Pharmaceutical Research and Manufacturers of America (PhRMA) filed a lawsuit in federal court challenging S792, claiming the law violates Federal Medicaid statute. On September 18th, the U.S. Department of Health and Human Services approved Florida's state plan amendment to establish a preferred drug list and negotiate rebate agreements with manufacturers that are in addition to those required by Title XIX of the Social Security Act. A few days later, a Federal court magistrate in Florida denied PhRMA's request for a preliminary injunction, saying: "I don't see that the Federal law prohibits a prior authorization program that furthers other state interests…as long as it keeps intact the idea of the [Federal Medicaid] formulary. In early January of 2002, a Federal judge let S792 stand, finding that "Florida's list steered doctors and patients towards certain preferred drugs, but didn't prevent access to non-preferred drugs." (KFF, February 2002)

Other states' attempts at containing prescription drug costs have also been met with lawsuits from PhRMA (i.e, Michigan and Maine). Oregon is working hard to create an "evidence-based" drug program that would limit drugs prescribed to those found to be cost effective. Currently, new drugs that are approved and introduced in the market only have to be tested against a placebo drug. Their effectiveness over current drugs in the same class is not tested and, consequently, increases costs without substantial increases in quality. Evidence-based research centers and state collaboration to "globalize the evidence, localize the decisions" are ways that states are being encouraged to collaborate on winning the fight against increasing prescription drug costs.

There are ways that Utah can join in the efforts to contain prescription drug costs. The following are some suggestions made by Utah's pharmaceutical directors and other state Medicaid programs:

- Continue to seek out select drugs or drug groups for restriction (i.e. limit the access to COX-2 inhibitors)
- Develop a broad-based preferred drug list
- Increase the discount on the AWP to 15% (a problem with increasing the discount is the claim that manufacturers simply increase the AWP to offset the discount)
- Reduce dispensing fees
- Increase the co-pay to maximum allowable
- Set hard limits on the type of (brand-name) or quantities of prescriptions allowed

There are pros and cons to each of these suggestions, but some are starting to prove more and more effective without a substantial decrease in the quality of care that patients receive. The client, state, pharmacy provider, medical provider and good patient care all have significant stakes in direct restrictions. Downstream costs, such as increases in hospitalizations and morbidity and mortality, figure into the equation as well. Many of these concerns would be satiated if thorough research on the cost effectiveness of drugs in each class were conducted at either the state or national level by unbiased research teams.

4.1 Which coverage expansion options were selected by the State?

There was general agreement that the Primary Care Network (PCN) model (the 1115 Waiver), as proposed by the Utah Department of Health, would provide coverage to a significant portion of the target population under 200% FPL. This waiver was approved and the PCN was implemented on July 1, 2002. Because of the economic environment, individuals up to 150% FPL are covered. Part of the 1115 Waiver includes a premium-subsidy program. The State has named this program Covered at Work. The subsidy allows for these individuals to participate in their employer-sponsored health insurance programs.

4.2 What is the target eligibility group under the expansion?

The Primary Care Network (PCN) Proposal targets a new eligible population of adults, who do not qualify for Medicaid and have incomes up to 150% of the Federal Poverty Level.

4.3 How will the program be administered?

The Primary Care Network (PCN) leverages the existing Department of Health (DOH) infrastructure with few incremental employees. The Utah Department of Health, Division of Health Care Financing, and the Office of Children's Insurance and Access Initiatives administer the program. Leveraging the existing programs' infrastructure has kept costs down considerably. In addition to leveraging the existing DOH infrastructure, a Steering Committee with by-laws has been formed, with the Chair (not a member of the department) facilitating objective input.

4.4 How will outreach and enrollment be conducted?

Primary Care Network and Covered at Work have used grassroots outreach strategies. For PCN, these strategies have been successful, though other strategies are being examined to announce open enrollment sessions due to the necessary timing and effectiveness of these sessions.

For Covered at Work, these strategies have been less successful and new ideas are being examined. Outreach was launched with radio ad libs and press releases. Also, a press conference was held involving the community. A website was developed with an online application. Additionally, collateral materials (posters, brochures, etc.) were used. CHIP families, who were at or below the 150% of the Federal Poverty Level, received a post card announcing the new program – PCN.

Enrollment is conducted by Utah Department of Health's eligibility staff who are stationed in various community sites throughout the State, including co-location with the Department of Workforce Services, Community Health Centers, and Local Health Departments. A very local presence insures a statewide grassroots interest and pulse to the program.

Once capacity was reached, outreach has focused its efforts around open enrollment time periods. See Section 4.17 for specific examples of outreach strategies.

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

For both the Primary Care Network (PCN) and Covered at Work programs, there is a $50 annual enrollment fee. PCN has minimal co-payments. Premiums are not required for either program. House Bill 212 was introduced during the 2003 legislative session. This bill allowed the health department to reduce the enrollment fee to $15 for PCN enrollees who are eligible for the state's General Assistance Program. These people have incomes less than 50% FPL. Then in the 2004 legislative session, HB 86 was introduced and passed. This legislation reduced the enrollment fee to $25 for all remaining PCN and Covered at Work enrollees with less than 50% FPL. An 1115 Waiver amendment was submitted to Health & Human Services (HHS), which would allow enrollees who have access to employer-based coverage to receive a $50 per month subsidy to enroll in their employer's plan. This amendment was approved and has become the Covered At Work program.

4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

The benefit design is a primary care package focusing on prevention. Specific services include physician, pharmacy with a 4 prescription per month limit, some lab and x-ray, medical supplies, emergency services, health education, management of chronic disease, and preventive dental. Inpatient services will be donated by Utah's hospitals based on an aggregate value of $10 million per year.

Minimal co-payments are required for certain services. For example, a $5 co-pay is charged for prescriptions, and a $5 co-pay for physician visits. These amounts are equivalent to approximately one third of what is required under the State employee's health plan to reflect the lower income status of this group.

4.7 What is the projected cost of the coverage expansion? How was this estimate reached? (Include the estimated public and private cost of providing coverage.)

The Primary Care Network is using $500,000 from the state general funds to pay physicians for inpatient ancillary costs. Utah's hospitals are donating $10 million of on-going free hospital care. An additional $17.5 million for covered services (e.g., emergency room, outpatient, lab, x-rays, prescriptions) will be funded for a total of $28 million. The State estimated that since it will be paying for actual services used, rather than prepaying "actuarial use" as an insurance product, the cost will be relatively low. Cost benefit was based on pricing out benefits, by examining utilization patterns (for these benefits) among the Medicaid population.

4.8 How will the program be financed?

The Primary Care Network is financed through Medicaid dollars that will be generated by modifying the Medicaid benefits for non-aged, non-disabled, non-institutionalized Medicaid adults (1931 adults) to that comparable to what Utah State employees receive, and in recognition of their low income status imposing cost-sharing at approximately 50% of the level required by the State employee plan. The Department of Health also rolled the state-funded program for non-categorical adults (UMAP) into the waiver program. The amount previously funded for UMAP was $3.2 million.

4.9 What strategies to contain costs will be used?

A limited benefit package with reasonable cost sharing is used which directs enrollees to the most cost beneficial service. Strategies include:

- Enrollee education of benefits
- Better awareness of urgent care services outside of ER
- Enrollee paired up w/ Primary Care Physician (PCP) – not required but suggested
- Measures to restrict abusers (drugs may only be purchased from 1 pharmacy)
- Ongoing review of benefit package (levels)

- Limit the benefits (specific services covered, maximum pharmacy benefits – 4 prescriptions/month)
- What services are covered, and to what extent
- Co-pay structure
- Case mix of clients (parents vs. non-parents – 2:1)
- Case managers call heavy users and provide case management education

Additionally, enrollment is capped based on the availability of funds. Enrollment is currently capped at 25,000 for both programs (A maximum of 19,000 for PCN and 6,000 for Covered at Work).

4.10 How will services be delivered under the expansion?

The delivery network consists of the existing statewide Medicaid fee-for-service providers. For medical, pharmacy and dental benefits, Primary Care Network members can choose from a panel of Medicaid providers that have agreed to accept PCN patients. However, specialty care and inpatient hospital care are excluded from coverage, but are provided through donated services by referral.

Inpatient Hospital
If a PCN client needs surgery or to stay in the hospital for more than 24 hours, patients may contact PCN's inpatient hospital case manager. Utah's hospitals have generously agreed to provide this care and it is coordinated through PCN staff.

Specialty Care
Specialty care like cardiology, neurology, and urology are not covered by PCN. If a client needs to see a specialist, PCN case managers will try to arrange this care. Primary care providers may request specialty care by sending a referral. Clients may contact the case managers via a toll-free number.

The above information has been shared with many primary care Medicaid providers to ensure that they are aware of specialty and inpatient hospital services available through PCN.

4.11 What methods for ensuring quality will be used?

The Department of Health will review utilization patterns, conduct periodic review of claims, do select medical audits, monitor complaints, and conduct satisfaction surveys. Frequent surveys will be conducted to determine the success of the program regarding access to care, coverage, whether or not the needs of the insured are being met, any weakness/changes needing to be made and managing the access to care.

4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

To determine program eligibility, the Department of Health will use the same staff who determine Medicaid eligibility and who are aware of other coverage resources. If eligible for Medicaid, the individual will be enrolled in Medicaid.

The Covered at Work program offers a subsidy to individuals who are income-eligible for PCN but have access to, and have not yet purchased, employer-sponsored medical insurance. Once enrolled in Covered at Work, members are eligible to receive $50 each month towards their insurance premium.

A couple of obstacles that have been encountered as the Primary Care Network and Covered at Work programs have been rolled out include the need for donated care (PCN uses donated inpatient and specialty physician services) and the need to coordinate the timing of signing up on Covered at Work with the open enrollment of their employer-sponsored private insurance.

4.13 How will crowd-out be avoided and monitored?

Coverage will be denied to those who have access to health insurance, and enrollment will be denied if the individual voluntarily terminated other coverage within 6 months. An individual (a cost-sharing employee) whose premium costs exceed 5% of his or her gross salary and who is NOT enrolled in the employer's healthcare plan is defined as "not having access" to health insurance.

4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

The Department of Health will track enrollment and utilization data through eligibility (PACMIS) and claims payment (MMIS) systems.

The program will conduct disenrollment surveys of those not renewing PCN enrollment. Additionally, the program will collect data on member months, per member per month costs, claims by category of service, and donated services in both specialty care and inpatient services.

4.15 How (and how often) will the program be evaluated?

The program has been granted a five-year demonstration timeframe, after which it may apply for an extension. Evaluation will be on-going to ensure that the program is meeting the needs of the client and is being run in the most cost-effective manner. Additionally, quarterly and annual reports to the Centers for Medicare and Medicaid Services (CMS) will be filed to ensure that the program is following the terms of the 1115 Waiver.

Health Outcome Evaluation

Since PCN program inception (July 2002), the Office of Health Care Statistics (OHCS) has been in charge of evaluating the health outcomes of PCN enrollees. The outcome evaluation is intended to answer the following question on PCN impact: "Does the availability of primary and preventive care improve the enrollees' health status and enhance their success in achieving employment offering full coverage?" To accomplish this objective, OHCS developed a comprehensive self-health assessment tool to gather baseline health information on all first-year PCN enrollees. Beginning in July 2002, health assessment forms were distributed at eligibility offices statewide during PCN orientation sessions. Health program representatives and local health department workers mailed back completed forms every Friday to the OHCS. This process ended in February 2003. Over 10,000 usable surveys were received and used for analysis in two separate PCN reports located at http://www.health.utah.gov/hda.

Beginning in August 2003, OHCS conducted a Year 2 health self assessment of persons who re-enrolled into the Primary Care Network from July 1 to December 31, 2003. The purpose of the second health assessment was to evaluate if changes in health status and/or utilization of services occurred among PCN enrollees since initial enrollment into the program.

The reassessment questionnaire contained a total of 44 questions. Among the 44 questions, thirty-two (32) were the exact same questions asked at the initial health assessment. Twelve (12) new questions inquired about the respondent's personal doctor or nurse, satisfaction with PCN program and potential barriers for co-pays. OHCS created six monthly random samples from the six monthly eligibility files for PCN renewed enrollees from July to December 2003. The sample sizes were 500 per month, and a total of 3,000 for six months.

On the 5th of each month, the Utah Department of Workforce Services provided a PCN eligibility file identifying re-enrollees from the previous 30 days. OHCS employed a self-administrated mail survey similar to the initial assessment. The mail survey consisted of a 5-wave mail protocol with three questionnaire mailings and two reminder postcards. Every five or six weeks, OHCS initiated the first survey mailing. The survey period for each monthly sample lasted for approximately 45 days.

To maximize the response rate, OHCS utilized two incentives that were also employed in the 2002 mailing of health assessments to the former UMAP population. The first incentive was a pen included in the first mailing package. The second incentive was to mail a 30-minute free phone card to each PCN respondent after OHCS received his/her returned questionnaire. Further, survey cover letters were written in English on one side with Spanish on the other enabling the re-enrollee to request a Spanish version of the survey by mail. OHCS developed the appropriate amount of Spanish materials – including postcards and surveys - to meet the needs of the survey population. Partly as a result of these measures, the response rate for the re-enrollee survey was over 75%.

UDOH/OHCS has performed several smaller-scale surveys related to PCN evaluation. A list with research question for each survey is below (contact OHCS for detailed information):

Study 1: PCN Enrollment Denials – phone survey

Research question: Why did those "denied" PCN applicants NOT provide the requested additional information for PCN to decide whether they are eligible?

Study 2: Access to PCN Providers – phone survey

Research question: Do PCN enrollees experience difficulty in finding a primary care provider who accepts PCN coverage?

Study 3: Hospitalization – phone survey

Research question: Why do PCN enrollees disproportionably utilize <XXXX> Hospital in comparison with other large Salt Lake County hospitals

Study 4: Disenrollment from the Primary Care Network – mail survey

Research question: Why do PCN enrollees decide not to re-enroll in the program?

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

The main factors leading to the selection of the PCN option were financial and political feasibility, the economic condition of the State, concerns over a large expansion (which have had questionable results in other states), and difficulty in being sustained. Additionally, the State had historical problems being able to maintain the Medical Assistance Program (UMAP) and needed to restructure it within current funding constraints - a commitment made to the state legislature. The State rolled the UMAP program into the PCN program.

For expanded coverage, the Primary Care Network covers a new audience – the uninsured with low incomes, but who do not qualify for Medicaid. PCN greatly depends on donated care to provide a fiscally feasible solution.

Consensus on the original four proposals was reached after deliberation in several workgroup sessions, which consisted of constituents from Utah's health care community.

Given the economic condition of the State and concerns over a large expansion, only the PCN was pursued for implementation. The other three original proposals (expand the safety net, three-share program, 1931 expansion/1115 waiver for parents) were researched and proposed to the Steering Committee, but considered financially and politically unfeasible at this time. Examples from other state expansion programs show that expansions are currently having difficulty in being sustained. In the event that the economic condition of the state improves, these proposals should be given further consideration.

Policy considerations that worked *in favor* of each program are as follows:

Expand the Safety Net: It's easy to build on existing programs, and it could serve a wide variety of special populations and low-income individuals
Three-Share Program: Leverages private dollars not currently in the health care market, requires personal responsibility, does not require a large public dollar investment, and does not have a residency requirement.
1931 Expansion/1115 Waiver Combination for Parents: Provides coverage to a large segment of the target population, maximizes federal matching funds, is well tested in other states, keeps parents in same program as children, and has several flexibility options.

Policy considerations that worked *against* each program are as follows:

Expand the Safety Net: It is difficult to raise more funding and build additional infrastructure, future funding is uncertain, and it's hard to convince the legislature of the importance of funding such programs.
Three-Share Program: Public funding source is uncertain, it would require the creation of a new system, start-up costs could be costly (pent-up demand and administration), and enrollment in the beginning could be slow.
1931 Expansion/1115 Waiver Combination for Parents: Likely the most expensive option. It only covers parents (childless adults would be excluded), possible Medicaid stigma remains, and expands "entitlement" programs. The GAO recently published a report criticizing states' use of SCHIP dollars, which are allocated for children, to fund care for adults.

4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

On February 9, 2002, Health and Human Services (HHS) Secretary Tommy G. Thompson formally approved Utah's request for a Federal 1115 Medicaid Demonstration Waiver to expand benefits for primary care and preventive services to about 25,000 residents who otherwise would not have access to health coverage. This waiver allows Utah's Medicaid program to provide a limited medical package (Primary Care Network or PCN) to working adults whose income is less than 150% FPL. The PCN model is akin to a "family physician" model that provides basic and general health care services to people seeking assistance for screenings to identify or prevent illness and disease or needing treatment for common illness or injury. It also provides care for the management of chronic disease. The PCN was implemented on July 1, 2002.

In connection with the waiver, Governor Michael O. Leavitt signed into law House Bill 122 enabling even more uninsured working Utahns to obtain health coverage through Covered at Work, which partners with employers and the private insurance market. Information from CU2002's focus groups and key informant interviews was used to inform and guide development of this partnership.

Recent state legislation has demonstrated that Utah completely backs the "covering the uninsured" program, through financial support and political backing. The outreach program continues to make positive public influences via news releases, media relations, etc. for CHIP, PCN, and Covered at Work.

PCN staff conducted the following outreach efforts to implement PCN:

- Prepared a fact sheet for the Governor's website to be used for the 2003 State of the State address
- Coordinated PCN to be highlighted in the Health Insurance Access Hotline, an annual feature of a local newspaper, the Deseret News, which included a phone-in hotline and three newspaper articles in January of 2003 and 2004
- Highlighted PCN during *Cover the Uninsured Week* 2003 and 2004, which included public relations, health fairs, several meetings with lawmakers and stakeholders, website updates, representing UDOH at a variety of meetings and events, and monitoring the media
- Highlighted PCN on talk shows and in news interviews
- Designed a PCN website and made it available to the public. The website includes information about eligibility for the program, how to apply for benefits, and the current status of the program. The site has a link to the online PCN application and includes links to other services such as Medicaid and CHIP (Utah's Children's Health Insurance Program)
- Sent a mailing, in partnership with "The Governor's Commission on Women and Families," to all licensed child care providers in Utah letting them know that they may be eligible for PCN
- Made available PCN information to physicians through health fairs, public relations, and the PCN website
- Made available PCN information to the general Utah population through health fairs, public relations, and the PCN website
- Rewrote PCN materials to make them lower cost to produce and easier to understand
- Developed a PCN brand that represents the target audience to make PCN materials identifiable and enhance name recognition
- Translated PCN materials into Spanish and distributed in many ways, including on the website
- Conducted PCN outreach to hotel workers and their employers through a banner and e-mail blasts on "UtahHospitalityJobs.com"

Additionally, PCN staff performed the following activities to help enrollees understand the benefits of the PCN program:

- Wrote, developed, printed, and devised a process for distribution of a handbook that explains PCN to members. This handbook includes information about benefits, providers, and health resources. This handbook, the PCN Member Guide, is now distributed to PCN members when they enroll. It is also available in Spanish
- Developed a PCN Provider list
- Established a toll-free phone number to access the specialty care case managers
- Called new enrollees to review benefits and educate them on how to access care

Enrollment Sessions and Communication

In November 2003, PCN reached capacity. The public was notified via a news release and website information. Community partners, advisory council members, and other stakeholders were also notified. At that point, the PCN discontinued continuous enrollment of the program. Applications were planned to be taken when enrollment allowed for additional applicants.

In May of 2004, the first PCN open enrollment was held. This open enrollment was held in conjunction with CHIP open enrollment so that those applying for CHIP could also be evaluated for PCN. Parents who were not applying for CHIP were also invited to apply. Outreach was conducted via public relations, website information, a mailing to about 700 community partners, public service announcements, and health fairs.

Covered at Work Implementation

Covered at Work began accepting applications in August of 2003. A news conference was held in May of 2003 to announce the program to the public. In August a news release was issued to notify the public that applications were being accepted. Materials including applications, brochures, posters, a brand, and a website were developed to implement Covered at Work. Outreach agents (members of the Utah Association of Health Underwriters) were trained to deliver information about Covered at Work to people looking for health insurance options. When PCN reached capacity, the Covered at Work information was rewritten to separate the Covered at Work brand from the PCN brand to reduce confusion about which program was accepting applications. In addition, new information about coordinating Covered at Work enrollment with employer-sponsored health insurance was added. Information about Covered at Work was mailed to health underwriters, child care providers, and people who had been denied PCN because they had access to health insurance at work. Further outreach strategies are currently being evaluated.

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

The following options were proposed and considered by our workgroup participants, but due to a variety of factors, they did not receive the detailed attention like our previous proposals.

Employers provide a basic primary care package or low-cost insurance
This option is now available with the passage of House Bill 122, as described above. Several commercial carriers are marketing new insurance products that meet the intent of HB122.

Allow employers to buy-in to Community Health Center (CHC) care
After consideration of such a program, workgroup participants concluded that it would cause administrative burden and unnecessary effort for coverage lacking a catastrophic component.

Implement clinics next to Emergency Rooms in order to divert the high cost of non-emergency care
This idea was still considered a plausible option, but it did not specifically address the grant's goal of providing *coverage* for the target population.

Develop/expand a mobile clinic system for rural areas
This proposal was viewed as part of expanding safety net services. The mobile clinic system already exists with a fair amount of success, but it would only serve a small segment of the grant's target population.

Add an employer catastrophic component to the PCN
There was concern over the fact that the PCN only covered primary care, and workgroup participants wanted to ensure that further effort would be made to increase the amount of care covered under the PCN. An 1115 waiver amendment was recently submitted to HHS that would provide a subsidy ($50 pm/pm) for PCN enrollees to buy-in to their employer's health care plan. This effort is hopefully one step toward more inclusive coverage for individuals eligible for the PCN.

Increase education and outreach for health programs with a Community Health Worker component
This proposal is still considered a necessary service in Utah, but it did not address the specific goal of the grant to develop options that increase coverage. Increasing education and outreach was a major theme of our focus group study. Focus group participants related their detachment from the process and cost of health care. Increasing the consumer's awareness of how the health care system works could potentially result in more efficient and responsible consumption of services.

Restructure Medicaid spend-down
Efforts from Utah Issues and Representative Becky Lockhart helped in the passage of House Bill 37 during the 2003 Legislative session. This will allow the Health Department to use 100% of the FPL as the income standard (instead of the previous spend-down amount of $382/mo.) to determine Medicaid eligibility for aged, blind, and disabled individuals.

Home health mid-level provider network
This proposal was an innovative and revolutionary approach to the manner in which health care is administered today. Its idea to use mid-level providers to provide primary care in the home has potential success, but because of its non-traditional structure and untested effects, it did not receive further attention.

Single Payer System
This proposal received a considerable amount of attention. The idea was presented to and commented on by the grant's Steering Committee. Doctor Joseph Q. Jarvis developed his version of such a system in Utah and continues to advocate for a single payer system throughout the state. Although the proposal would provide coverage to all Utahns, it was not pursued further for two reasons. First, HRSA requested that proposals be more incremental in nature. Second, based on the political nature of Utah and the success of single payer proposals in Vermont and Massachusetts, the proposal was deemed politically unviable.

Vouchers for individuals to buy insurance through employers
This proposal could be similar to the subsidy that would be provided to PCN enrollees, or to the Premium Assistance Program in Massachusetts. The idea of vouchers did not receive extensive support.

Expand options with Medical Savings Accounts (MSAs)
This proposal still has potential to increase access to health care in Utah, but it would not serve the lower-income, target population of the grant.

Employer Mandates (public or private)
Mandates are not popular in Utah.

Individual Mandates (public or private)
Mandates are not popular in Utah. Even with the mandate for individuals to have car insurance, the rate of coverage is still approximately only 75%.

Community-Wide Expansion Model

<u>Cost-Sharing Model (based on Muskegon County, Michigan model)</u>
Cost-Sharing Model (Based on Muskegon County's Access Health Program) with an employer buy-in to CHC's component. The cost-sharing model is based on a cost-sharing model practiced in Muskegon County Michigan. Premium expenses are shared amongst the employer (30%) the employee (30%) and the community (40%). The total employee expenditures end up at $38 per month. In Muskegon County, the employer pays approximately 22 cents per hour more for each employee's premiums. These percentages could be adjusted according to acceptable contributions in Utah. The community contribution ends up being $1 for every $2 contributed by the employer and employee. Funds from the community are comprised of federal Disproportionate Share Hospital (DSH) funds and local government, community, and foundation funds. 10 percent of the provider fees are donated back to the program for on-going 3rd party administrative costs. Revenue stream at full enrollment is approximately $4.4 million with 3,000-enrollment estimate. The total per member per month cost, including administration, has been approximately $130 after the first few months. Sole proprietors cost a little more ($160). Pharmaceutical costs have been $10.50 per member per month.

Local providers contract with this Community Health Project and agree to the reimbursement and benefit packages created by the community members (including physicians, employers, and

advocates) themselves. Community Health Centers could also be considered as contractors to provide care. Small- to medium-sized businesses in the county with uninsured full and part-time employees, whose median income is $10 per hour or less, will be targeted. Employers must have not provided coverage for the past 12 months. The plan could be marketed to certain industry sectors that have had traditionally low health insurance coverage rates.

Program evaluators looked at a cost-sharing proposal for Utah based on the success of the Muskegon County model and found that the cost-sharing model would best benefit those that are full-time and part-time employees and who oppose public assistance and pride themselves in paying for their own health care. 55 percent of the uninsured in Utah would probably fit into this category. Evaluators also looked at the leverage of resources attractive to policymakers concerned about increases in public expenditures: no US/Utah residency requirement, provision of both primary and catastrophic care, employee dollars contributing to the increase in dollars flowing to the health system, and a reduction of the burden of uncompensated care.

Hesitations to implement this program were several:

- Enrollment for Muskegon County was slow in the beginning. It would require a creation of a new system
- Claims are higher in the beginning of the program than normally anticipated
- Some portions of the funding used to finance the program were not guaranteed
- Start-up costs could be costly
- Accommodating particular special populations
- Finding community funding.

(Covering the Uninsured 2002 Meeting Minutes June 18, 2001)

This proposal never materialized into an actual program.

<u>Strengthening Community-based Health Centers and the Safety Net</u>

Strengthening Utah's Community-based Health Centers and the Safety Net would involve allocation of additional funds for those programs already providing services for the uninsured. This proposal considered looking at the UMAP program with its part of Health Clinics of Utah. Getting this program passed as a Federally Qualified Health Center look-alike may provide more funding from the federal level and could improve eligibility standards. Additional safety-net expansions might include the expansion of the Community Health Center (CHC) system in Utah (which has been an initiative of the Bush Administration). Additional ideas proposed for the safety-net expansion included mobile clinics and the operation of clinics next to Emergency Rooms to provide non-emergency care.

Individual policies generally provide fewer benefits compared to group plans, require higher out-of-pocket expenses, and often exclude coverage that individuals with pre-existing health problems are likely to need. Utah's low income advocacy groups and many individual focus group participants also expressed particular concern over the lack of coverage for mental health treatment and prescription drugs in many of the available individual plans.

Program evaluators stated that although it would be easy to build on existing programs, it could serve a wide variety of special populations and very low-income people. It is difficult to raise more funding and build additional infrastructure for programs that already suffer from funding cuts and shortages.
(Covering the Uninsured Meeting Minutes 2002 June 18, 2001)

Consequently, before this proposal could materialize the UMAP program lost complete funding in 2001.

Primary Care Model.
Although a viable program, it would need the following elements to ensure success: 1) strengthened safety net, 2) catastrophic coverage component, and 3) employer contribution.

Because future funding was uncertain and it was difficult to convince the legislature that funding was important, this proposal never materialized.

Private-Employer Model
The Private-Employer Model uses a voucher system – the same concept as the CHIP expansion with employer buy-in. In addition, there would be a possible avenue for catastrophic coverage to combine with PCN.

Expansion/Buy-in Program
This solution seems to include some of all of the options. When viewed as a whole, these combine to provide a broad range of coverage, which is seen as a possible next step following implementation of PCN. Some other pieces include: 1) Section 1931 Expansion to Parents, 2) CHIP Waiver to Parents, 3) Small Business and Self-Employed CHIP Buy-In (same as voucher), and 4) Section 1115 Waiver (same as PCN).

Section 1931 Expansion.
Section 1931 expansion to Utah parents below 100% FPL would offer states additional flexibility by permitting them to apply earned income disregards differently for Medicaid applicants and recipients. This would alleviate some of the pressure on the program should Utah face budget restrictions. Section 1931 also makes it possible for states to extend eligibility periods for transitional Medicaid.

Arguments in favor of this expansion are as follows:

- Maximizes federal matching funds. For every $1 Utah spends to expand coverage, the federal government contributes $3. Utah's match rate will decrease slightly in October 2001 to 70% from the current 71.4%.
- Uses expansion of Section 1931. Expansion method is well-tested. Over half of the states have expanded through use of Section 1931 beyond the minimum Federal requirements established in 1996 under the Personal Responsibility and Work Opportunity and Reconciliation Act (PRWORA).

- Uses several flexibility options - i.e. enrollment can be capped in face of budget constraints
- Requires no waiver
- Builds on effective medical assistance systems; minimal administrative changes would be needed to implement
- Keeps parents in same program as kids
- Builds upon other positive experiences Utah has had using a similar expansion tool, section 1902(r)(2) waiver for pregnant women
- Improves health-related status (since implementing the 1902(r)(2) expansion for pregnant women) for the following: outcomes for pregnancy and childbirth, infant mortality birth defects, and number of low birth-weight babies

Some negative components of the expansion were as follows:

- Remains the most expensive option. Annual cost to Utah is approximately $10 million.
- Covers only parents. Childless adults (including the current UMAP population) would need another expansion tool.
- Continues possible Medicaid stigma
- Expands "entitlement" programs
- Continues tradition of piecemeal, incremental reform and fails to address current administrative inefficiencies and marketing and advertising-related waste (see single payer proposal for details

(Covering the Uninsured 2002 Meeting Minutes, July 2, 2001)

<u>Section 1115 Waiver to Cover Childless Adults</u>

In order to extend coverage to categorically ineligible groups like childless adults, states must apply for an 1115 Waiver. Under this 1115 Waiver proposal, Utah would meet the budget neutrality requirement by modifying the current benefit package and introducing minimal/manageable cost-sharing for enrollees above 150% FPL. Under this waiver approach, expansions could be phased in incrementally, starting with all uninsured Utahns below 75% FPL. Uncovered medically necessary services, such as dental or mental health services, could be obtained on a fee-for-service basis through the use of a wrap-around mechanism.

Utah looked at this proposal as a possibility for the following reasons.

- Adults <100%-200% FPL generally cannot afford insurance on their own.
- Uninsured people suffer from poorer health than the insured, and although clinics and other safety net programs offer some care, the uninsured lacks access to care.
- They are less likely to have a regular source of care, more likely to delay seeking needed care, and more likely to go without needed care.
- Overall, the uninsured have a 25% higher risk of death than the insured [Medicine, 1999 #175].
- It supports independence and self-sufficiency. With an adequate CHIP-like benefits package, the target population will be more stable in the workforce; thus less likely to need public assistance down the road.

- Access to insurance in low-wage jobs is likely to worsen. Utah's job forecast for 2000-2005 predicts that *most* of Utah's job growth will occur in low-skill and low-paying jobs.
- Typically these jobs are part-time and temporary, offering little or no opportunity for advancement, and do not include benefits. In other words, access to health insurance for families in transition from welfare to work is likely to worsen.

(*Covering the Uninsured 2002 Meeting Minutes June 18, 2001)*

Single-Payer Plan (a Non-Profit Health Insurance Plan Covering Every Utahn)

A single payer plan would be a statewide, non-profit health insurance plan covering every Utahn for all medically-necessary services including: acute, rehabilitative, long term and home care, mental health, dental services, occupational health care, prescription drugs and supplies, and preventive and public health measures. Boards of expert and community representatives would assess which services are unnecessary or ineffective, and exclude them from coverage. Private insurance duplicating the single payer coverage would be proscribed. Patient co-payments and deductibles would also be eliminated.

Health insurance for every Utahn can be achieved without increasing the total revenues already spent for health care in the State. Total expenditures for health care would be set at the same proportion of the gross state product spent for health care during the year previous to the formation of the single-payer plan. Government expenditures, including both Federal and State sources, already account for nearly two-thirds of total health spending in the US (and presumably in Utah). These resources would be diverted to the single-payer plan. The remainder of health care funding in the US comes in equal portions from private employers and out-of-pocket individual payments. These revenue streams could be re-routed to the single payer through progressive taxation of the business community and individual citizens. This would be budget neutral, meaning that on average Utah's citizens and businesses would pay no more for health care after the creation of the single payer plan than is the case now.

The first step in the process of converting Utah's health care financing into a single-payer plan would be passage of legislation or a referendum declaring the intent of the citizens of Utah to cover all legal residents of Utah without increasing revenues for health care. A carefully planned, independent study of the feasibility of single-payer health insurance for all Utahns while maintaining budget neutrality would be a major step in preparing the citizens of Utah for this legislation (or referendum). The vast majority of Utah's residents with health insurance are members of non-profit plans. These plans all have a similar mission; they are organized and operated "exclusively for charitable, educational or scientific purposes" (quoted from the IHC articles of incorporation). Thus, there will be few displaced investors or altered sense of mission for these organizations as they are merged into a single payer plan. Many Utahns with health coverage are funded for these benefits by government programs, including Federal and State government employees. These Utahns will be as well or better served by a single-payer plan. The 200,000 uninsured Utahns would finally realize the benefits others receive. Thus, the legislation or referendum could simply declare that all uninsured Utahns and all Utahns receiving health insurance from government programs or non-profit entities will as of a certain date receive their health insurance from the single-payer plan in Utah, pending approval of the Federal government. Federal approval would require an act of Congress. The final phase of single payer

reform in Utah would then commence, during which all for profit HMOs and health insurance entities in the state would be phased out over a few years, while implementation of the payment structures for health care facilities and practitioners would be organized and executed.
The Single Payer Group, Joseph Q. Jarvis MD MSPH

The Single Payer Proposal was a major component in the expansion options. Joe Jarvis spearheaded this idea and attempted to convince the planning committee to consider this initiative. Joe Jarvis continues to advocate this proposal around the State of Utah.

The evaluation committee was originally set-up to study public initiatives for covering the uninsured. Each of these proposals were carefully looked at and evaluated with the goal to increase coverage for low-income, uninsured individuals, and improve access to health care.

4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

Utah residents are more likely than nationwide respondents to feel public programs have a social stigma, express concern for abusing the system, and don't want to have government assistance. The mistaken perception of not being eligible is also a major barrier. Utah has a more difficult audience in general.

CHIP often reaches out to families to let them know that getting their kids covered offers peace of mind through reduced worry about raising a child with limited resources (time and money). Similar attempts could be used for PCN and Medicaid.

Utah has increased outreach and simplified enrollment by offering online applications. Currently, UDOH offers online applications for CHIP, PCN, Covered at Work, with the Medicaid currently being developed. The e-government initiative is penetrating more agencies and programs. By providing an option to apply online, the government saves numerous resources and offers convenience to the public. These online applications are consistent with the Governor's 1,000-Day Plan. Former Governor Leavitt set an aggressive e-government goal of offering all appropriate state government services online by 2004. During past CHIP open enrollments, as many as 44 percent of applications were submitted online. The CHIP and PCN renewal processes also have been simplified in the past year to reduce barriers to staying enrolled and simplify the process for staff.

CHIP and PCN are at capacity and applications are only accepted during open enrollment sessions. Outreach efforts to enroll eligible children have been highly successful. During past CHIP open enrollments 6,249 children were accepted in June 2002, 8,856 children were accepted

in November 2002, 8,921 children were accepted in July 2003, and approximately 8,900 children were accepted in May 2004.

Further efforts to reach eligible but not enrolled adults for Covered at Work are being examined.

The State of Utah has launched a new website called Utah Cares that tries to match individuals and families with government programs for which they qualify or with other community resources. This new web portal is the enhancement of a phone referral service known as "211."

Additional methods for addressing eligibility include: check offs on school enrollment forms, extra efforts from tribal workers, bilingual outstation workers - eligibility staff, Covering Kids Coalition, health fairs, ability to apply via FAX, phone, etc., advertising for CHIP, and mini grants targeting ethnic minorities.

Existing programs include the Children's Health Insurance Program (CHIP), Medicaid and the Primary Care Network (PCN). A combined strategy was used to target individuals eligible for these programs – primarily by placing outreach workers in health facilities throughout the State. In addition, the Utah Department of Health worked to identify potential clients via a number of strategies, including:

- Coordination with allied agencies to distribute information and provide presentations on eligibility determination
- Identification of clients through church groups in every major religious denomination in the state
- Identification through schools
- General press coverage of the existing outreach network
- Development of advertising material for a number of State health programs with links to Medicaid and CHIP
- Collaboration with Early Intervention Programs

The Utah Department of Health maintains ongoing collaboration with a number of partners throughout the state including:

- School and education sites, such as school clinics, in-school social workers, etc.
- Homeless Adult and Youth Centers
- Ethnic populations, particularly Hispanic and Native American groups
- Child care centers and associations
- County health departments

Concerning Medicaid and CHIP enrollment, the Department awarded approximately $200,000 to various agencies with the goal of providing improved health access to the medically underserved. Partners in this endeavor included Utah Issues Center for Poverty Research and Action, and the Association for Community Health.

In addition, as the Department of Health moved forward with implementation of the Primary Care Network, Department staff have worked with staff on Salt Lake County's Community Access Project Grant to help ensure a coordinated effort that best serves the county's low-income population.

Section 5. Consensus Building Strategy

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure?

The project was governed by a Steering Committee composed of twelve community leaders representing the following groups and agencies:

- Rural Health Providers
- Utah Department of Health – 2 representatives
- Ethnic Health Agencies
- Utah Health Insurance Association
- National Federation of Independent Business (representing small employers)
- Utah Issues (advocates for Utah's low-income population)
- Utah Medical Association
- University of Utah Center for Health Policy
- Local Health Departments/Utah County Health Department
- Utah Hospital Association
- Native American Tribes

The Utah Department of Health served as the lead agency, which provided staff and a project team manager to oversee and coordinate activities for the grant. During the first six months, the Steering Committee met monthly, and thereafter met on an intermittent basis.

The Steering Committee had two primary functions. First, the steering committee created the project's guiding principles, which are:

- Make health care accessible to as many people as possible, under 200% FPL
- Achieve political and fiscal viability
- Cover greatest need first
- Preserve private sector investment in the financing of health care
- Promote individual responsibility for the cost of health care
- Target populations with workable and acceptable solutions

The second primary function of the steering committee was to evaluate the proposals that were developed and presented by the project workgroups. Proposal evaluation included commenting upon specific aspects of the proposals and selecting proposals for continued review.

Because of the Steering Committee's diversity, this process proved to be a valuable component in the decision-making structure – particularly for the two functions aforementioned. Although considerable time was spent to reach consensus on the guiding principles, they provided a strong framework for the work ahead. As proposals were being reviewed and discussed by the Steering Committee, consensus among this diverse group usually was attained. After being presented with appropriate data and the options created by the workgroups and staff, the Steering Committee was able to make sound recommendations based on the original guiding principles.

5.1a How were key state agencies identified and involved?

The Utah Department of Health Executive Director identified potential steering committee members and invited participation from key State agencies. The goal was to bring together individuals representing those affected most by health access issues, as well as those dedicated to studying the policy and public health implications of access.

Other agencies were involved initially via invitation to an all-day Partnership Summit - Covering the Uninsured (CU) 2002 Summit. (Details are included in Section 5.2). An all-inclusive mailing compiled from lists provided by Steering Committee members and the Utah Department of Health, was used to identify agencies throughout the state and invite them to participate in the process. Again, the goal was to involve agencies representing a wide range of constituencies.

5.1b How were key constituencies incorporated into the governance design?

Key constituencies included in the workgroups (i.e., legislature, community advocates, providers, administrators) reported to the Steering Committee. As mentioned, the Steering Committee itself included key groups and agencies necessary for success of the grant. While proposals were being developed, consistent communication was maintained between the workgroup members.

5.1c How were key state officials in the executive and legislative branches involved in the process?

The Insurance Commissioner's office, legislators and legislative staff, were invited to the initial Partnership Summit. The few legislators that attended actively participated in the break out sessions, as well as some of the follow-up work group meetings. Additionally, state officials

were invited to a two-day session on Three-Share Programs, which the co-chair of a Legislative Task Force on Health Care Access attended and took a significant interest in exploring ways to make the program work in Utah. Finally, the CU 2002 staff conducted interviews with legislators to acquire a better perspective of what key decision makers think about health care access, and what the role of government should be to ensure adequate access.

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?

Early in the project (June 18, 2001), a Partnership Summit was held for all interested parties. Invitations were mailed to over 600 people representing a wide range of organizations and interests. In addition, many groups were encouraged to invite their members as well as any other interested parties.

The first half of the Summit agenda included the following:

- An Overview of the HRSA Grant
- A review of Health Insurance Coverage in Utah
- An overview of Utah's Safety Net
- Structure of *Covering the Uninsured 2002 (CU2002)* Project (timeline and guiding principles)
- An overview of the workgroup's role

During the first half of the Summit, an overview of the project was given, as well as background data on Utah's uninsured. In the afternoon, breakout sessions were held. The sessions were designed to begin brainstorming possibilities for expanding health access to low-income populations. Participants could choose the breakout group they wanted to attend. CU 2002 staff collected contact information to inform them of upcoming proposal team meetings. More than half of those attending the Summit continued to participate in at least one proposal team meeting.

The second half of the Summit consisted of the attendees organizing into four workgroups according to their own interests. Workgroups were charged with developing proposals for covering the uninsured that would be presented to the project steering committee after a period of about eight weeks. Workgroups elected their own chairperson at the Partnership Summit.

Workgroups were originally structured as follows:

<u>Public workgroup</u>

- Expansion Programs
  - CHIP (present program in Utah)
  - Medicaid (present program in Utah)

- Single Payer
- "Direct" provision of care

Private workgroup
- Employer-based
- Tax Incentives
- Subsidies
- Medical Savings Account
- Reinsurance/stop loss

Public/Private workgroup
- Expansion Programs
  - CHIP
  - Medicaid
- High Risk Pool

Community-wide workgroup
- Combine elements from other workgroups to provide coverage

Small "consultation teams" were formed as mechanisms for community advocates, providers, employers, and health care industry interests to provide input to the grant.

17 focus groups were conducted throughout the State of Utah. The average number of participants per focus group was 10 people per session. Research consultants with the HRSA grant facilitated the focus groups, and funding came strictly from HRSA.

The distribution assured that researchers obtained a geographically representative sample of individual views, in both rural and urban areas, about the experience and consequences of being uninsured. Focus group questions were aimed to provide a deeper understanding of the barriers involved in being uninsured or on public assistance.

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?

Several activities were used to raise public awareness and support regarding expansion possibilities to cover the uninsured. Two of the key methods used were: public information hearings and a two-day conference. Also, public awareness was generated throughout the State via discussions in focus groups and key informant interviews.

Utah's request for a Section 1115 Waiver to develop its Primary Care Network created many questions within the community. To address concerns, the CU 2002 staff held a two-hour

information meeting open to the public. Attendance included approximately 40 individuals from various organizations and advocacy groups.

During November 2001, the CU 2002 staff partnered with *The Matheson Center For Health Care Studies* at the University of Utah to host a two-day conference on the appropriateness of a cost-sharing model approach (similar to the program presently offered in Muskegon County Michigan) for Utah. We invited Vondie Woodbury, Director of the Muskegon Community Health Project to present at this conference. Break out sessions were held for members of Utah's Legislative Task Force for Access to Health Care, employers, insurance industry representatives, community advocates, providers, and our steering committee. The two-day conference concluded with a roundtable/lunch where community representatives discussed the strengths and weaknesses of such a model for Utah.

In addition, a website (http://health.utah.gov/hrsa) was developed where many of the grant activities were posted. Included in this website was: meeting schedules and minutes, project staff, steering committee, timelines, and other information that allowed interested people to stay abreast of key updates, regardless of location or time constraints.

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

The planning effort raised awareness of issues and brought attention to legislators. Due to the increased awareness, legislators and advocacy groups began to collaborate. Involvement from a wide range of community members has generated a broader sense of understanding amongst all parties with regard to the obstacles that exist in providing access to health care for all Utahns.

The current policy environment is favorable in supporting the existing health care programs, as well as exploring new ways to address the needs of all uninsured individuals in Utah. To date, both Primary Care Network and Covered at Work programs have been implemented.

For now, Utah will remain in a "wait and see" status with respect to additional funding for PCN before additional initiatives are explored. With more and more Utahns going without insurance each year, there is a greater desire than ever before for Utah to insure the next level – the working poor who do not have access to health insurance.

Section 6. Lessons Learned and Recommendations to States

6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

State-specific data was essential in identifying and recommending various solutions to State-wide healthcare issues. Such data points as availability/cost of coverage, uninsured rates by geographical locations and demographics, and availability of medical care in urban and rural areas, are extremely useful for better understanding specific issues and how best to address them with the needed support and 'buy-in' from all stakeholders.

Qualitative research was essential in identifying issues medical and dental providers face when offering services under programs such as Medicaid, CHIP, and currently the Primary Care Network (PCN). Issues such as program awareness, reimbursement rates, utilization and effectiveness were all discussed.

For example, one key informant interviewee stated, "The problem is with Medicaid. It is difficult to get Medicaid to cover procedures important to good patient care. Programs need to encourage better self-reliance and take responsibility for choices that adversely affect health."

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

Since minimal grant funding was required, the Utah Health Status Survey *(UHSS)* was the most cost-effective data collection activity, at a general level. The UHSS is an independent resource that the HRSA Grant was able to tap into. Also, the UHSS allowed for specific questions to be asked of the uninsured. This survey is the source for Utah's most accurate and State-specific data. To capture details at a more granular level, the key informant interviews and focus groups were used. Information from the key informant interviews provided perspective from an administrative viewpoint. The focus groups provided more insight from the end users of the various healthcare coverage options. Time was the major cost associated with conducting the

key informant interviews, whereas the focus groups required time, as well as additional costs such as incentives for participation – food, money, etc.

All three of the above-mentioned strategies *(UHSS, key informant interviews, focus groups)* were effective in collecting data. Overall, we found that the $50 incentive for each focus group participant was the most effective means for increasing the response rate. Medical and dental providers showed a general interest in the grant activities when explained to them. This generated many candid, informative interviews throughout the state.

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

Although several were proposed, no additional data collection activities were conducted. The major reasons that additional research was not conducted include: budget constraints, methodological difficulties, time constraints, lack of follow up, and lack of trained personnel. Overall, the need for sufficient funding to support a full study limited the ability to conduct additional in-depth studies. Some of the major data collection activities that were not conducted include: Spanish-speaking focus groups, and statewide studies – we would have suggested more focus groups in rural areas where we believe the surveys were used too sparingly. Even in urban parts of Utah, additional studies would have been very helpful in better understanding in-depth issues.

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

All three of the above-mentioned strategies *(UHSS, key informant interviews, focus groups)* were effective in collecting data. Overall, we found that the $50 incentive for each focus group participant was the most effective means for increasing the response rate. Key informant interviews allowed for candid responses.

Also, upon completion of Primary Care Network surveys, gel pens were distributed to survey participants. Additional questions to the Primary Care Network would have improved this survey method. Throughout the various survey gathering times, multiple methods, such as using

the Health BRFS Standard (up to 15 callbacks, using addresses and phone #s taken from databases, etc.), and others were used to ensure that accurate information was collected.

Based on previous experiences with Utah surveys and advice from national survey vendors, we included small incentives to improve response rates for our Discrete Choice, Employer and PCN Health Status surveys. These included $1 bills, gel pens or 20-minute calling cards, depending on the size of the survey and the nature and extent of the information we were asking for. In addition, we made advance phone calls to the businesses randomly selected to participate in our employer survey to identify a contact person with knowledge of employee benefits, verify the address, and gain preliminary agreement to participate in the survey. Follow-up postcards and phone calls were made to non-responders.

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under this HRSA grant? Does the State have plans to conduct that research?

Several additional data collection activities and questions were left unanswered. Some of the key questions include:

- Can coverage of only preventive services (doctor care visits) prove to reduce frequency and costs of hospital stays?
- By offering Primary Care Network coverage, are we eroding the existing health insurance? Does this influence employers to scale back on coverage?
- Over the course of enrollment, do the sicker stay with the program, while the healthier opt out (after one year on the program)? (the State is currently pursuing this one)
- Understanding the pent-up demand (chronic medical conditions), is there some point at which costs will come in line with average insured client?
- Does the health status improve for chronically ill patients on the Primary Care Network? (Over a one-year period? Over a two-year period? etc.)

The State is currently pursuing research to answer the first, third and fifth questions, and will later attempt to answer the second and fourth questions.

6.6 What organizational or operational lessons were learned during the course of the grant? Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

During the course of this grant, several organizational and operational lessons were learned, some of which include:

- Initially, there were high expectations, but as the project progressed, the reality of the project scope and political realities became more complex
- Throughout the course of the project, there was the thinking of "diffusion of responsibility"
- The impact of information gathered during the course of a grant continutes to grow as reports are disseminated to stakeholders
- The HRSA activities provded a new forum for communication among decision makers, advocates, providers and individuals

The only change the State has proposed and implemented as a result of the HRSA grant is the limited-benefit PCN Program.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

Some of the key lessons resulting from the HRSA planning effort, as well as responses from health plans for the Primary Care Network and Covered at Work programs include:

- Key informant interviews leading to politically and industry viable solutions
- Timing is critical w/ Covered at Work (as w/ any employment-based program) – potential clients cannot enroll whenever, but rather must work within open enrollment time frames
- Many employers want employees to opt out – less costly to employer, w/ more cost paid by employee
- Employers will generally resist such programs – covering employee costs are not appealing to any type of business needing to make a profit and watching the bottom line
- Members of insurance groups (health underwriters) assured insurance, Covered at Work would have filled up quickly – as it stands, the Covered at Work program continues to struggle to find new enrollees

- Cost is inherently the biggest issue/obstacle - $50/month to subsidize is not much for a Covered at Work recipient who may have premiums ranging from $300 - $700/month (or more), and who may only make up to $2,000/month
- General program complexities prohibit potential enrollees from joining or continuing with the program – complexity of premium reimbursement is one such example
- Higher rates of success achieved by gathering and disseminating information by working through groups, like the Utah Chapter of the National Federation of Independent Business, and local Chambers of Commerce

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

For policy planning, Utah has four main recommendations:

First, take advantage of national databases. It's difficult for states to get large enough data samples to accurately make strong conclusions. Many national databases are available that compliment, solidify, or help to clarify studies done in states.

Second, get qualitative data to augment the numbers from the quantitative data collected. Because quantitative data is more objective, qualitative data is an effective way to interpret the numbers.

Third, collaborate. Talk with other states and amongst your own state and community agencies about what studies they have done and the methodology by which they did it. Share data with each other. Don't "reinvent the wheel."

Fourth, hire a national consultant who already has a thorough knowledge of the national environment and what other states have done.

6.9 How did your State's political and economic environment change during the course of your grant?

Economic Changes

Utah's economy slowed during 2001, especially after September 11, 2001. Utah's recession continued throughout 2002 and 2003. Unemployment hovered near 6.0% for the year and nonagricultural employment fell 1.0% during the same period. From 2001 to 2003, Utah's population grew 3.6%. (www.governor.utah.gov/gopb) Due to all of the above-mentioned factors, the demand for health insurance services increased.

Political Changes

During the course of the grant, three key PCN proponents/administrators left the State of Utah:

1- Governor Michael O. Leavitt
2- Executive Director Rod Betit
3- PCN/CHIP Director Chad Westover

In 2001, under a recently approved Medicaid waiver, Utah adults age 19-64 with incomes under 150% FPL were eligible for coverage under a new "Primary Care Network" insurance plan.

HB 122 – 2002 Health Insurance Benefit Design (Governor signed substitute bill) was passed. The act amends provisions related to Accident and Health Insurance. The act permits a carrier to offer less or different coverage than the basic benefit package, the minimum standards required by the Commissioner of Insurance, any other health insurance mandate required by the state law when the Department of Health offers similar coverage as a Medicaid waiver. The act requires the Department of Health and the Insurance Commissioner to report to the Legislature on the implementation of the benefit package in the public and private sector and on partnerships between the public and private sector to increase access to health insurance.

6.10 How did your project goals change during the grant period?

When the grant began in April of 2001, the economy was somewhat stable, although at a slight downturn. Initially, the project focused on ways to increase and expand coverage to those without access to health care. Focus was placed on the best ways to implement insurance expansion to cover more people. Funds were available but required convincing constituents to invest in health programs. After 9/11 and economic downturn, the project refocused its priorities and began examining ways to preserve existing programs. Focus is also being placed on determining how effective the implementation has been, and how we can improve the current policies, process, and operating procedures for future expansions.

6.11 What will be the next steps of this effort once the grant comes to a close?

We will disseminate the information that we have gathered to all constituents and hope that the collaboration, momentum, and interest will continue. Some of the cost containment recommendations are being discussed in this year's legislative session, and the dialog should continue once the grant comes to a close. Additionally, more information on uncompensated care, cost-shifting, and overall strain on the "safety net" is needed. Better understanding of cost drivers and opportunities for cost containment would also be helpful to decision makers. The role of primary and preventive care in future cost containment needs to be more carefully documented so that available funds can be more effectively allocated.

Section 7. Recommendations to the Federal Government

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

The Primary Care Network program was approved for a five-year demonstration (February 7, 2002 – February 7, 2007). A minimum of 12 months prior to expiration, an extension application must be filed in order to continue on with the current program. The PCN 1115 Waiver proposal required waivers in the following areas:

1- Statewideness — Section 1902(a)(1)
To enable the State to offer managed care systems only in certain geographic areas of the state.

2- Amount, Duration, and Scope — Section 1902(a)(10)(B); 42 CFR 440.230-250
To enable the State to offer a reduced benefit package.

3- Comparability — Section 1902(a)(10)(B)
To enable the State to impose different cost-sharing amounts on individuals than that imposed by the state plan.

To enable the State to offer different benefits than offered to other populations eligible under the state plan.

To enable the State to include additional benefits such as case management and health education not available to Medicaid beneficiaries enrolled in a managed care delivery system.

4- Enrollment Fee — Section 1902(a)(14); 42 CFR 447.53-54
To enable the State to impose enrollment fees on certain demonstration participants in excess of that permitted in Section 1916(a)(1).

5- Freedom of Choice — Section 1902(a)(23)
To enable the State to restrict freedom of choice of providers.

6- EPSDT — Section 1902(a)(43)(A)
To enable the State to not cover certain services required to treat a condition identified during an EPSDT screening.

7.2 What coverage expansions not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

Instead of looking at specific coverage expansions and the changes in Federal law that would be required, we looked at general barriers that prevent or reduce quality and /or access to health care. We came up with an extensive list of state, Federal, and market policies that are prohibitive, but will only include a few in this abbreviated version.

- Cost of prescription drugs
- Illegal and legal immigrant laws
- Lack of information dissemination/education/outreach for health care available
- Disconnect between the purchase and consumption of health care
- Interface between law and medicine. Criminalization of medicine and malpractice
- Small business tax law
- Reimbursement rates for Medicare and Medicaid

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

Provide funding at the state level. Funding at the state level will allow for more accurate data collection (under nation-wide standards) by focusing at state-specific data (variables and needs). Providing financial support will also allow states to develop and implement their own survey tools. For states that already have a survey mechanism for determining the uninsured, this funding would allow individual states to carry out surveys more frequently. More frequent surveys will more accurately determine demographic changes and better analyze who is now uninsured, that before was not. Most importantly, nationwide standards must be adhered to in order to ensure consistent surveys and findings from state to state.

7.4 What additional research should be conducted (either by the Federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

Additional research to assist in identifying the uninsured or developing coverage expansion programs should be conducted. Studying different uninsured patterns would prove to be very useful. Below are several examples of potential research studies:

- What kind of patterns lead to being uninsured?
- On average, how long are people uninsured?
- What are people's needs during periods of being uninsured?
- How can the state target financial relief to periodic uninsureds, in order to assist them to make it to the next stable insurance time? (i.e. frequently between jobs – assistance w/ COBRA)
- What are the characteristics of "chronically uninsured" people?
    - Uninsured choose not to be insured
        - Financially OK
        - Healthy and do not need insurance
    - Uninsured are so sick that nobody will insure them
- What are the exemptions of covered benefits?
    - Study of pre-existing condition in new (underwritten) health policies …
        - Provider will "insure everything except your 'bad' knee at the normal rate"
        - Are health providers more willing to insure "higher risk" patients with certain exclusions?
    - Study of health policies where there are no exemptions to covered benefits …
        - Provider must cover all illnesses
        - If too costly, are health providers unwilling to take these financial risks?

APPENDIX

BASELINE INFORMATION
(2001 UHSS)

Population:
2,295,967
Number and percentage of uninsured:
199,100 8.7%
Average age of population:
28.8
Percent of population living in poverty (<100% FPL):
9.4%
Primary industries:
1- Agriculture, Fish, Forestry, Construction
2- Mining, Manufacturing
3- Professional Services
4- Retail & Other
Percent of employers offering coverage:
54%
Percent of self-insured firms:
34%
Payer mix:
1- Medicaid = 6%
2- Medicare = 9%
3- Private = 80%
4- CHIP = 1%
5- Other Government Plan = 4%
Provider competition:
Top 8 companies represent 83.4% of commercial market and 70.2% of Utah's overall domestic market
Insurance market reforms:
No major reforms to report
Eligibility for existing coverage programs (Medicaid/SCHIP/Other):
1- CHIP: up to 200% FPL, no asset test, no other insurance
2- PCN: up to 150% FPL, no asset test, no other insurance
3- Medicaid: different levels of eligibility
    a. Pregnant women: up to 133% FPL, asset test
    b. 0-6 years old: up to 133% FPL, no asset test
    c. 6-18 years old: up to 100% FPL, asset test
    d. Aged & disabled: up to 100% FPL, asset test
    e. TANF adults: up to 50% FPL, asset test
Use of Federal waivers:
1- 1115 Waiver = PCN & PCN Covered at Work
2- 1915(b) and 1915(c) Waivers = Long-Term Services in Managed Care Environment

SUMMARY OF QUESTIONS ANSWERED BY FINAL REPORT

1.1 What is the overall level of uninsurance in Utah?

8.67% (199,100 individuals) uninsured of the total population in Utah
6.51% (50,600 individuals) uninsured children in Utah

1.2 What are the characteristics of the uninsured?

Income: The highest rate of uninsurance is among individuals living in households earning less than $15,000 annually (27.05%). Individuals living in households earning between $15,000 and $25,000 annually represent 19.79% of the uninsured. The 50,600 uninsured children (0-18) in Utah 35,645 live in households with annual incomes at or below 200% of the Federal Poverty Level (FPL). *(Utah Health Status Survey, 2001, UHSS)*

Age: Individuals in the 18-34 years age group have the highest rate of uninsurance (13.8%). This group represents 45% of all the uninsured individuals in Utah. 24.8% of the uninsured are under age 18; 45.9% are 18-34 years; 20.0% are 35-49 years; 8.6% are 50-64 years; 0.7% are over 64 years. *(UHSS)*

Gender: Utah males were somewhat more likely to be uninsured than females. 52.4% of the uninsured were male; 47.6% were female. *(UHSS)*

Family Composition: Individual adults who had "Never Married" were most likely to be uninsured (15.2%), followed by those who were "Divorced, Separated, Widowed" (12.2%). Respondents who were "Married, living as married" were the least like to be uninsured (7.6%). However, because of the large percentage of people belonging to the "Married, living as married" category, this group accounts for 54.7% of all the uninsured in the state. *(UHSS)*

Health Status: Individuals in the "Fair/Poor" health were more likely to be uninsured (9.3%), than those reporting to be in "Good/ Very Good/Excellent" health (8.6%). *(UHSS)*

Employment Status: "Unemployed/Other" adults were the most likely to be uninsured (15.7%). Students (14.7%), part-time workers (12.2% uninsured) and homemakers (10.9% uninsured) were the next most likely to be uninsured, followed by fulltime workers (9.5%). Retirees were the least likely to be uninsured (1.6%). Because of the large percentage of people working full time, this group accounted for 57.3% of all the uninsured in the state. *(UHSS)*

Availability of private coverage: The typical Utah resident has an employee group policy with an HMO style plan administered by a domestic health insurer. 37.24% have commercial health insurance plans; 33.65% have employer sponsored plans; 21.35% have plans administered by commercial insurers; 5.47% are on the Public Employee Health Program (PEHP); 4.91% are on the Federal Employee Health Benefit Plan (FEHBP); 1.92% are on other known employer plans. (Utah State Insurance Department). The Utah Health Status Survey indicated that 80.5% of all Utahns with health insurance were covered by private plans, and 71.5% have policies obtained through their current or former employer or union.

Availability of public coverage: Approximately 10.3% of all Utah residents receive their health insurance coverage through the State Medicaid program. The unique number of enrollees is about 223,800. The current number of enrollees is about 180,000. In general, Medicaid is available to pregnant women (133% FPL), children under 6 (133% FPL) children 6-18 (100% FPL) the disabled (100% FPL) and the Medically Needy. Medicare covers approximately 14.53%. The

Children's Health Insurance Plan (S-CHIP) currently has 28,000 children enrolled on average during the year and determines eligibility up to 200% FPL. Due to increased demand for the program, CHIP has had to instate an enrollment cap. The Primary Care Network (PCN), which is available to adults up to 150% FPL who do not qualify for Medicaid, currently has room for 19,000 enrollees, and an additional 6,000 enrollees for the Primary Care Network – Covered at Work Program. *(UHSS)*

Race/ethnicity: Data from the 2001 HSS shows Hispanic residents are more than three times as likely to be uninsured (25.84%) than Non-Hispanic minority residents of the state (7.19%) Nationwide, 77% of blacks, 65% hispanics, 79% whites have health insurance offered through their employer. But the percentage of workers who decline offers is about 15% for each of these groups. Finally, 81% of blacks, 67% of hispanics, and 89% of white workers have health insurance coverage. *(UHSS)*

Immigration status: Foreign-Born Population is 158,664; Percent Foreign-Born 7.1%; Illegal Resident Population 15,000, uninsured numbers are not available for this population. (US Census Bureau 2000)
An MSNBC publication stated that Utah's illegal resident population could be as high as 75,000.

Geographic location: Rural Utahns were more likely to be uninsured than those who live in urban areas; Wasatch Front (Urban), 8.20%; Non-Wasatch Front (Rural) 10.15%. *(UHSS)*

Duration of uninsurance: The majority of uninsured in Utah fall into two categories, those that have been uninsured for less than six months (23.9%) and those that have been without insurance for four years or longer (37.4%). <6 months, (23.9%); 6 months –1< year, (9.2%); 1 year - <2years, (15.9%); 2 years - <3 years, (7.2%); 3 years - <4 years, (6.4%); >=4 years, (37.4%). (UHSS)

1.3 Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion options?
Young adults age 18-34 years old (15 percent without health insurance; Adults without a high school education (26 percent); Persons in households with incomes less than $15,000 a year (24 percent); Unemployed adults (19 percent); Persons of Hispanic ethnicity (25.8 percent); Persons living outside the urban Wasatch Front (12 percent); Residents of several more rural health districts (e.g., Tri-county and Southwest Utah Health Districts, (17 and 16 percent, respectively); Persons who reported fair or poor health status (12 percent). (UHSS) The current targeted coverage expansion (1115 Waiver and associated amendment) focuses on low income (<150% FPL) working adults.

1.4 What is affordable coverage? How much are the uninsured willing to pay?
Studies varied according to geographic location (rural versus urban), current income, and current amount being paid toward health care. Rural residents estimated "affordability" ranged anywhere from $50-$300 per month. Urban residents range was from $50-$700 per month. Many of these affordable amounts were based on what individuals were currently paying for coverage. A recent NBER paper noted that, depending on the definition, health insurance was affordable to between one-quarter and three-quarters of the uninsured in 2000. Although income is related to the purchase of coverage, it is not perfectly related to insurance status. It is not the only factor driving decisions.

The authors' argument was based on an analysis of choices made by similarly citated people. They surmised that about half of the uninsured can "afford" health insurance based on the non-

elderly uninsured adults are in families with incomes below 100% of the Federal Poverty Line (FPL). On the other hand, 30% of the nation's uninsured are in families with incomes above 300% of FPL. Clearly, there are many individuals who can "afford" to buy health insurance, but have opted to remain uncovered (uninsured afforders). Although income is related to the purchase of coverage, it is not perfectly related to insurance stats. Attitudes and values are important individual determinants of health insurance "affordability".

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

Review of available data reveals that eligible persons do not participate in public programs for the following reasons:

- 38% who were eligible but unenrolled indicated they were not aware of any health insurance coverage programs that provided free or low-cost coverage for families who can't afford health insurance coverage.
- The ones who were aware of CHIP and Medicaid gave lower and more negative ratings to their overall "feelings" regarding these public programs than those who were enrolled in the programs
- 56% of those who were eligible but not enrolled believed they were eligible, but 14% didn't know for which program.
- 30% believed they were ineligible, and 14% didn't know whether they were eligible or not.
- 19% said that they would be "not at all likely" to enroll their family in Medicaid if they were eligible, and indicated that they were able or wanted to provide for their family's health care needs on their own (22%); didn't like participating in government programs (16%); found it too much of a hassle (8%); didn't believe they would qualify (8%); thought others needed it more than they (5%); or were not concerned because they would take their family to Emergency or Urgent Care when the need arises (5%). (The Wirthlin Group Report, October 2002)

1.6 Why do uninsured individuals and families disenroll from public programs?

The only specific data that we collected comes from the SCHIP program. After a survey was conducted among Utah participants, those on SCHIP were found to disenroll because of the following reasons:

- 60% said their child got private insurance
- 21% said they are no longer enrolled because a change in income made them ineligible. It is unclear how they came to this conclusion
- 8% reported that their child moved to Medicaid
- 8% said their child was no longer eligible because of age. It is unclear how parents determined that their child was too old for SCHIP.
- 3% gave other reasons *(The Wirthlin Group, SCHIP Disenrollment Survey, April 2002)*

1.7 Why do uninsured individuals and families not participate in employer sponsored coverage for which they are eligible?

The most common reason given is that the coverage is still unaffordable, unless health insurance is covered 100% by the employer. However, there will always be a group who won't purchase insurance no matter what the cost, simply because they don't value insurance the same as others. Some individuals stated that health insurance coverage would require half of their monthly income.

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

The Utah Health Insurance Association (UHIA) commissioned a public opinion and market research of Utah residents during November 2001. The results of their study suggested that uninsured respondents placed less importance on having an employer who offers health insurance. A large percentage of insured respondents (84%) said that it was very important for their employer to offer health insurance compared to 64% of uninsured respondents who felt that way. Still, 10% of insured respondents and 8% of uninsured respondents indicated that it is not very important that their employer offer health insurance. However, when we asked the focus group participants why they were uninsured, although affordability was the number one answer, the second most common response was that the employer didn't offer insurance. This answer seems to imply that workers have an expectation of accessing coverage through the workplace. When coverage was not offered through the workplace, rarely did the employee seek coverage through individual means.

1.9 How likely are individuals to be influenced by:

Availability of Subsidies: Policies designed to expand health insurance coverage tend to focus on workers in low-income households, low-wage workers, and small firms. However, many low *wage* workers are secondary earners in higher *income* households and are already insured. Targeting subsidy dollars to low-*income* workers would extend eligibility to a large share of uninsured workers and would be less likely than targeting low-*wage* workers to subsidize workers who already have coverage. Targeting workers in small firms is the *least* likely to reach a high share of uninsured workers.

Tax credits or other incentives: Individual tax credits would need to be refundable to help low-income workers. It is clear that some effort would have to be made to increase awareness of the credit and make it easy to claim. The Center on Budget and Policy Priorities estimates that 15 to 20% of those eligible for the Earned Income Tax Credit (EITC, a refundable income tax credit which has been around for 30 years) miss out on the benefit because they don't know they qualify, don't know how to claim the credit, and do not know where to find free filing assistance. In addition, more than 15% of Federal EITC recipients fail to claim the state EITC for which they are eligible.

The Urban Institute suggests that employer tax credits are easier to administer than individual tax credits, but are not as likely to expand health insurance coverage. Public program expansions would work better than individual tax credits to reduce the rate of worker uninsurance for low-income workers, unless a tax credit subsidy is nearly equal to the price of an insurance policy. But public program expansions require a more elaborate eligibility determination system, whether through the tax system or a state welfare agency.

Reference: Urban Institute, Office of public affairs, Release, 8/29/01
Health Insurance Subsidies for Low-Income Workers Most Efficient way to Expand Coverage, Says New Urban Institute Report.

1.10 What other barriers besides affordability prevent the purchase of health insurance?

Education, ethnicity, and many other factors are associated with the demand for health insurance. For many individuals, having health insurance just isn't a priority or a recognized value. The 2001 Health Status Survey indicated that 21.5% of the uninsured said they didn't need or want health insurance. Top focus group answers after affordability included an inability to afford the self employed premium for which they were eligible; they indicated a lack of need because of

good health and have other priorities; for example, their children's needs, and ineligibility for public programs.

1.11 How are the uninsured getting their medical needs met?

The 2001 Utah Health Status Survey indicated that even among the insured, 11.4% were unable to get needed Medical, Dental, or Mental Health Care in the previous 12 months. Primary reasons for access problems were "can't afford" (7.19%), "service not covered by health insurance" (6.91%), and "could not find services in my area" (2.69%). *(UHSS)*

We asked our focus group and key informant respondents where the uninsured could go for care. The most commonly cited answers in our focus groups were: hospital charity care programs, religious organizations, family members, government programs, doctors' donations of time and skills, and local clinics (usually Community Health Centers, but some other areas had their own free, or locally low cost clinics). Some indicated that they just go without care.

1.12 What are the features of an adequate barebones package?

From a list of common benefits included in an insurance plan, we asked focus group participants to pick the top five minimum benefits that should be included in a benefits package. The most common answers were physician services, inpatient hospital, ER, immunizations, and prescription drugs.

When we worded the question, "If you had to create your own benefit package, what would be the top five benefits that you would include." The most common answers were physician services, ER, prescription drugs, lab and x-ray, and inpatient hospital. We found that consumers generally value insurance that includes the most highly utilized services, not necessarily those that would incur the highest cost.

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

The items below summarize such statements:

- Any time a medical condition threatens economic viability
- Any time a medical condition is not treated because it is not covered
- Depends on the means and needs of the individual

We asked this question in our key informant interviews and one Hospital CEO eloquently stated, "When the insurance company pays far below the cost of coverage, and when the insurance plan is oversold and the patient doesn't receive the coverage that he/she thought was included in the plan."

A legislator defined underinsured in two ways. One definition was, "When someone is faced with a catastrophic incident and doesn't have coverage, which ends in bankruptcy or financial ruin." The second definition stated, "For people who can't afford an $80 office visit, underinsured would be first dollar coverage unavailable, so it's dependent on one's financial resources."

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

Firms that offer coverage tend to be larger (<50 employees, 39.6%; 50 or more employees, 97.8%), involved in mining and manufacturing industries (84.4% compared to 33.6% in agriculture/construction, 56.7% in retail services), and employ at least 50% of their workforce full time (< 50% full time, 34.2%; 50 to 74% full time, 52.7%; >75% full time, 65.8%).

Cost of policies:

Premium costs vary most by group size and type of provider. Those with fewer than 50 employees average $2767 annually and those with 50 or more employees average $2552 annually for single coverage. "Any provider" policies have higher annual premiums (average, $2835) than "mixed provider" (average, $2632) or "exclusive provider" policies (average, $2382). The cost of employer-sponsored family coverage tends to vary less systematically, with the overall average at about $6069 annually.

Level of contribution:

Overall, the percentage of establishments that offer health insurance that offer at least one plan that does not require any contribution from employees for single coverage is 49.8%. The percentage of establishments that offer health insurance that offer at least one plan that does not require any contribution from employees for family coverage is 25.6%. Overall, enrolled employees contribute an average of 22.5% of the premium for single coverage and 22.9% of the premium toward family coverage in employer-sponsored plans.

Percentage of employees offered coverage who participate:

Individuals who work in smaller businesses (1 to 24 employees, 50.8%) and those who work in businesses where more than 50% of the employees are paid low wages (70.7%) are most likely to be eligible but not enrolled in employer-sponsored coverage. For companies with more than 50 employees and less than 50% with low wages, about 80% of the employees who are eligible for coverage do participate, 54% of Utah businesses offer health benefits to some portion of their employees. Smaller businesses, industry type, such as, agriculture, fishing, forestry, and construction, or professional services, and number of full time employees, are characteristics of firms that do not offer coverage. *(Utah Employer Survey)*

2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

Only 20% of the business owners who returned the survey indicated that a minor reason for not offering health insurance was lack of information to make a decision about benefits.

The Utah Employer Survey netted responses from 75 business owners or partners who do not offer health insurance to their employees. Major reasons for not offering health insurance are as follows:

- Revenue is too uncertain to commit to a plan
- Employees cannot afford it
- Cost of employee benefits are difficult to control

"A worker's ability and willingness to pay for health insurance coverage are key to a firm's decision to sponsor a health insurance program." *(Urban Institute, 8/29/01)*

2.3 How do employers make decisions about the health insurance they will offer to their employees? What factors go into their decisions regarding premium contributions, benefit package, and other features of the coverage?

National surveys indicate that employers make decisions primarily based on cost (81%), and expressed desires and satisfaction of the employees (45.3%). Many (61.4%) of those who offer health benefits indicated that they chose among a limited number of available programs for their group and 29.3% would be inclined to implement changes if more choice became available. (Employee Benefit Research Institute, 2002 Benefits Survey)

2.4 What would be the likely response of employers to an economic turndown or continued increase in costs?

More than 50% (53.3%) of the business owners who returned the Utah Employer Survey indicated that they would be unlikely to terminate coverage for their employees under any circumstances. Utah Department of Workforce Services reports that more than 32% of Utah retirees have experienced a loss of retirement health benefits or increased costs associated with group coverage under their former employer in the last year. In addition, required employee contributions have increased 11%, on average, for single coverage and 25% for family coverage in the last year. Many employees (44.0%) have experienced reduced benefits due to changes made by employers to control costs. Clearly, employers in Utah are passing some, but not all of the increased costs on to their employees who want to maintain coverage.

2.5 What employer and employee groups are most susceptible to crowd-out?

We did not address this issue specifically. With regard to tax credits, younger, healthy workers with incomes low enough to obtain the maximum tax credit would be most likely to drop out of their employer-sponsored group health insurance plan in favor of using a tax credit toward individual coverage. For these workers, the credit would need to cover the typical premium for a basic $500- or $1000- deductible individual health insurance policy. Small firms with a significant portion of workers who could qualify for a maximum tax credit and who currently realize lower tax subsidies for employer-sponsored coverage would be most likely to drop coverage, either after a number of lower-cost workers had withdrawn voluntarily from participation in the employer group or in response to their competitor's actions. *(Report based on Expert Forum, Institute for Health Policy Solutions, Individual Tax Credits and Employer Coverage: Assessing and Reducing the Downside Risks, August, 2002)*

2.6 How likely are employers who do not offer coverage to be influenced by:

The Utah Employer Survey results indicated that 57.3% of the 74 businesses that do not offer health insurance benefits were "Not at all likely" to start a health plan in the next two years. Only 6.6% were extremely or somewhat likely to do so, 17.3% were somewhat unlikely to do so and 18.7% were unsure. We specifically addressed the potential influence of purchasing alliances, subsidies, and tax incentives except in planning workgroups and did not pursue these options because, based on prior experience and understanding of political will, they had not been successful in the past, and/or were not politically viable.

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

Only 14.7% of the businesses who do not currently offer health benefits indicated that uncertain revenue was not a reason why they did not offer employee health insurance. On the other hand, 62.6% indicated that the costs of employee benefits are too difficult to control, and 53.4% indicated that their business did not need to offer health insurance in order to recruit and retain good workers. The most promising motivators for Utah businesses who do not currently offer

health insurance are likely to include an upturn in the economy and a downturn in unemployment rates.

Although availability of adequate revenue and competition for a good, steady workforce have a strong influence on employer decisions, employee variables are also important; 64.0% of the non-offers reported that their employees lack of ability to afford the premiums or their preference for wages and other benefits (53.3%), or the fact that employees had coverage elsewhere (spouses, 57.4%) constituted a major or at least minor reason why they did not offer health insurance.

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How do you define adequate?

Under the State Planning Grant, Utah did not attempt to collect specific data on the adequacy of existing insurance through survey or focus group activities. Utahns have a wide range of insurance choices, although IHC Health Plans Inc. holds 34.24% of the market share. Employers continue to have many policies and carriers from which to choose, However, anecdotal information from agents and carriers indicates that a growing number of businesses, particularly small firms, are beginning to choose more restrictive plans and are passing more costs to employees.

Utah has implemented a program called the Primary Care Network (PCN) for the "working poor" to obtain affordable and adequate coverage, however the PCN does not cover specialty care and inpatient hospital visits. Those without insurance or public coverage, primarily rely on the safety net or public assistance for health care options.

How do you define adequate?

This question was asked during our key informant interviews and had various responses, one person in particular defined adequate as, "Where the patient feels responsible for his/her own general health care costs – and are disinclined to overuse the system – but feel protected from catastrophic loss. There should be a way to incentivize the individual to maintain their health through insurance cost sharing requirements. The coverage would be dumbbell shaped, where the insurance plan would provide high coverage for preventative and catastrophic care, and the individual would be responsible for care in-between." – *Hospital CEO*

Another enlightening perspective came from a clinic administrator: "Historically, insurance has been for catastrophic needs. I think our society now would define adequate coverage as being for preventive maintenance, catastrophic illness, and any type of coverage that would help them to maintain a healthy lifestyle."

3.2 What is the variation in benefits among non-group, small group, large group, and self-insured plans?

Group policies reported higher premium per member per month ($126) than individual policies ($97). This may be due to underwriting practices. Conversion policies had the highest premium per member per month ($272). Less than one percent of the market was insured by conversion policies. The health benefits provided by these plans will range from comprehensive major medical benefits to single disease or accident only benefits. Information regarding the variation in benefits among different sized groups was not sought after for this report. (Utah Health Insurance Association, 2001 report)

3.3 How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace?

Self-insured employer plans provide health insurance coverage for 33.65% of Utah's residents. This may be broken down by Plans Administered by Commercial Insurers (21.35%); Public Employee Health Program (5.47%); Federal Employee Health Benefit Plan (4.91%), and Other Known Self-Funded Plans (1.9%). (Utah Health Insurance Market Report, July 31, 2002.) About 50.7% of Utah's workers who are enrolled in employer-sponsored health insurance are enrolled in self-funded plans. *(MEPS-IC)*

Since 1999, the number of health insurers providing comprehensive health insurance in Utah has declined by 19.4%. (From 18 to 14 domestic companies, and from 105 to 89 foreign insurers). Several moderately sized domestic insurers have left or are in the process of leaving the market.

When asked, Utah insurers cited lack of profitability and the growing number of self-insurers as their reasons for leaving the market.

3.4 What impact does your State have as a purchaser of health care (e.g., for Medicaid, SCHIP, and State employees?

As of 2002, 17.13% of Utah's population participated in Government sponsored plans. 6.11% (142,972) were insured through the Public Employee Health Program (PEHP). Medicaid medical assistance expenditures comprised just over 80% of the annual budget of the Utah Department of Health. *(Utah Public Health Outcome Measures Report, 2002)*

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

In our early workgroups, we spent a lot of time discussing the possibility of a single payer system as a form of universal coverage. Due to the conservative political environment in Utah, we concluded that a single-payer system would not be feasible. Such a system would require dramatic changes in the manner that taxes and health care are currently administered. Mandates and bureaucratic intervention are not strongly accepted forms of providing and accessing services of any sort.

Arizona reported that this type of system could also require mandatory employer-based coverage or taxation, more uniformity of benefits, more regulation of provider fees, and restrictions on patient choice of provider and services. *(Arizona HRSA Final Report)* All of these are unpopular in Utah.

3.6 How would universal coverage affect the financial status of health plans and providers?

We thoroughly addressed universal coverage through a single payer system. Philosophically it would not be a viable solution to covering the uninsured. We researched single payer initiatives by both Massachusetts and Vermont and found that the financial aspect of such a system would require major overhauls to the way plans and providers currently function. Profitability of both health plans and providers would most likely be regulated in a more stringent and unacceptable manner. A significant amount of collaboration and consensus between all stakeholders in the health care system would be required. Based on the experiences of Massachusetts and Vermont, we concluded that a single payer system would be even less politically viable in Utah.

3.7 How did the planning process take safety net providers into account?

A range of safety net providers was represented on the project steering committee and workgroups. We also consulted several safety net administrators and providers in our key informant interviews. Their experience and advice helped us to understand how and why the uninsured seek care in the manner that they do. Their knowledge enabled us to consider proposals that would benefit our target population.

The safety net was a significant consideration with development of the PCN. Implementation of the PCN was intended to lessen the burden currently placed on safety-net providers, such as hospital emergency rooms.

3.8 How would utilization change with universal coverage?

According to our focus groups and key informant interviews, there would most likely be overutilization. Several of our interviewees already experienced overutilization from those patients who already had free or low-cost coverage. Comments such as, "Medicaid patients come

in for everything" echoed throughout the state. If utilization did increase many providers would be unable to absorb the higher patient load. Several safety net providers expressed that they were already operating at capacity.

3.9 Did you consider the experience of other states with regard to:

Expansion of public coverage? We researched the public programs of Rhode Island, Minnesota, and Tennessee. They were states whose programs qualified individuals at a higher than average income. Their programs served as models to understand the implications of broader public program access.

Public/private partnerships? We considered Access Health of Muskegon County, Michigan, and Basic Health of Washington State.

Incentives for employers to offer coverage? Access Health of Muskegon County used some incentives to encourage employers to offer coverage. We could not find any other programs that had any significant incentives for employers to offer coverage that appeared viable in Utah.

Regulation of the marketplace? We compared health insurance benefit mandates across several states. We also evaluated Hawaii's success rate at mandating higher coverage. We found coverage levels weren't significantly higher than Utah.

The project's four original workgroups were presented with a large amount of data on all aspects of other states' experience. We compiled a library of information on our website and encouraged workgroup participants to supplement the database. Elements of programs currently being offered in other states are evident in many of the proposals presented by the workgroups to the project steering committee.

4.1 Which coverage expansion options were selected by the State (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credits for employers or individuals, etc.)?

There was general agreement that the Primary Care Network (PCN) model (the 1115 Waiver), as proposed by the Utah Department of Health, would provide coverage to a significant portion of the target population under 200% of the FPL. This waiver was approved and the PCN was implemented on July 1, 2002. Because of the economic environment, individuals up to 150% of the FPL are covered.

The second proposal receiving broad support was actually a combination of a 1931 expansion and an 1115 CHIP waiver for parents. This proposal has not received further action due to budget concerns.

PRIMARY CARE NETWORK PROPOSAL (PCN) 1115 WAIVER

4.2 What is the target eligibility group under the expansion?

The proposal targets a new eligible population of adults up to 150% of the FPL who do not categorically qualify for Medicaid.

4.3 How will the program be administered?

The Utah Department of Health's Division of Health Care Financing and Office of Children's Insurance and Access Initiatives are jointly administering the program.

4.4 How will outreach and enrollment be conducted?

The core element is the Utah Department of Health's eligibility staff who are stationed in various community sites throughout the state, including co-location with the Department of Workforce Services, Community Health Centers, Local Health Departments, as well as other areas. Applications are available on-line.

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

There is a $50 annual enrollment fee with cost-sharing requirements for services. There are no premium-sharing requirements. There are no cost-sharing requirements for American Indians who use I.H.S. or Tribal delivery systems. House Bill 212 was introduced and passed during the 2003 legislative session. This bill would allow the Health Department to apply for a waiver that would reduce the enrollment fee for PCN enrollees who are eligible for the state's General Assistance Program to $15. Additionally, House Bill 65 was introduced and passed in the 200 legislature session. It allows the Department of Health to apply for a waiver that would reduce the enrollment fee to $25 for people under 50% of FPL. An 1115 waiver amendment has also been submitted to HHS, which would allow enrollees who have access to employer-based coverage to receive a $50 per month subsidy to enroll in their employer's plan.

4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

Benefit design is a primary care package focusing on prevention. Specific services include physician, pharmacy, lab and x-ray, supplies, emergency services, health education, management of chronic disease, and preventive dental. Pharmacy is set up with a limit of 4 per month. There is a $5 co-pay for prescriptions on preferred list, and a $5 co-pay for physician visits. Some inpatient services will be donated by Utah's hospitals based on a capped aggregate value of $10 million.

Cost sharing is equivalent to approximately one-half of what is required under the State employees' health plan to reflect the lower income status of this group.

4.7 What is the projected cost of the coverage expansion? How was this estimate was reached? (Include the estimated public and private cost of providing coverage.)
The main PCN Program will cost $17 million. Additionally, the project will use $500,000 from the State general funds to pay for inpatient physician services. In addition, $10 million of on-going free hospital care donated by Utah's hospitals for a total of $27.5 million. The Department of Health based its estimates on the fact that reimbursement is for actual services used, rather than prepaying "actuarial use" as an insurance product.

4.8 How will the program be financed?
The PCN is financed through Medicaid savings that are generated by reducing the Medicaid benefits for non-aged, non-disabled, non-institutionalized Medicaid adults (1931 adults), partially by imposing cost-sharing at approximately 50% of the level required by the State employee plan, and partially by rolling a state-funded program for non-categorical adults (UMAP) into the waiver program. The amount previously funded for UMAP was $3.2 million.

4.9 What strategies to contain costs will be used?
There is a limited-benefit package with reasonable cost sharing, which should help direct enrollees to the most cost beneficial service. Additionally, enrollment will be capped based on the availability of funds. Hospitals have agreed to donate up to $10 million for inpatient services. Additionally, client education and case management will be used. (PCN enrollees are limited to 4 prescriptions per month under the current guidelines)

4.10 How will services be delivered under the expansion?
The delivery network consists of the statewide panel of Medicaid providers. Members of the network must guarantee a level of capacity to meet the needs of this new population. PCN members can choose from a panel of Medicaid providers that have agreed to accept PCN patients.

4.11 What methods for ensuring quality will be used?
The Department of Health will review utilization patterns, conduct periodic review of claims, do select medical audits, monitor complaints, and conduct satisfaction surveys.

4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?
The Department of Health will use the same eligibility staff who administer Medicaid and CHIP and who are aware of other coverage resources. If eligible for Medicaid, the individual will be enrolled in that program. Under this waiver amendment, individuals who meet the financial requirements to the PCN or have access to employer coverage, will be subsidized to allow them to purchase employee sponsored health benefits. If the waiver is approved, PCN enrollees who have not enrolled in their employers' plan will be eligible for the subsidy. The subsidy would be capped at the $50 per person per month cost.

4.13 How will crowd-out will be avoided and monitored?
Coverage will be limited to those who do not otherwise have access to health insurance, and will not be available to individuals who voluntarily terminated other coverage within 6 months.

4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

At a minimum, the Department of Health will track enrollment and utilization data through their eligibility and MMIS system. The Department of Health will be tracking disenrollments that result from the enrollment fee. In addition, each new enrollee completes a health status survey during orientation to the program and will be asked to provide follow-up information each year when they reenroll. Members who do not reenroll will be contacted in order to determine reasons for disenrollment.

4.15 How (and how often) will the program be evaluated?

Evaluation will be on-going and annual reports will be provided to CMS.

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

Given the economic condition of the state, and concerns over a large expansion, which have had questionable results in other states and difficulty in being sustained, the original proposals were considered financially and politically unfeasible.

Consensus on the original four proposals was reached after deliberation in several workgroup sessions, which consisted of constituents from Utah's health care community. Given the economic condition of the State and concerns over a large expansion, only the PCN was pursued for implementation. The other three original proposals (expand the safety net, three-share program, 1931 expansion/1115 waiver for parents) were researched and proposed to the Steering Committee, but considered financially and politically unfeasible at this time. Examples from other state expansion programs show that expansions are currently having difficulty in being sustained. In the event that the economic condition of the state improves, these proposals should be given further consideration.

Policy considerations that worked in favor of each program are as follows:

Expand the Safety Net: It's easy to build on existing programs, and it could serve a wide variety of special populations and low-income individuals.
Three-Share Program: Leverages private dollars not currently in the health care market, requires personal responsibility, does not require a large public dollar investment, and does not have residency requirment.
1931 Expansion/1115 Waiver Combination for Parents: Provides coverage to a large segment of the target population, maximizes federal matching funds, is well tested in other states, keeps parents in same program as children, and has several flexibility options.

Policy considerations that worked against each program are as follows:

Expand the Safety Net: It is difficult to raise more funding and build additional infrastructure, future funding is uncertain, and it's hard to convince the legislature of the importance of funding such programs.
Three-Share Program: Public funding source is uncertain, it would require the creation of a new system, start-up costs could be costly (pent-up demand and administration), and enrollment in the beginning could be slow.
1931 Expansion/1115 Waiver Combination for Parents: Likely the most expensive option, it only covers parents (childless adults would be excluded), possible Medicaid stigma remains, and

expands "entitlement" programs. The GAO recently published a report criticizing states' use of SCHIP dollars, which are allocated for children, to fund care for adults.

4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

On February 9, 2002, Health and Human Services (HHS) Secretary Tommy G. Thompson formally approved Utah's request for the 1115 Medicaid demonstration waiver. This waiver now known as the PCN was implemented on July 1, 2002. All other proposals are addressed in 4.16

In connection with the waiver, Governor Michael O. Leavitt signed into law House Bill 122 enabling even more uninsured working Utahns to obtain health coverage similar to the new Medicaid waiver through a partnership with employers and the private insurance market. Information from CU2002's focus groups and key informant interviews will be used to inform and guide development of this partnership.

During the 2003 legislative session, House Bill 212 was passed, authorizing the Department of Health to apply for a waiver to reduce the amount of the enrollment fee that must be paid by a person to obtain coverage under the PCN. The reduced enrollment fee will apply only to those who are eligible for the state's General Assistance Program after July 1, 2003.

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burdens, Federal restrictions, constituency/provider concerns)?

During the months of June and July 2001 approximately 21 people who represented various realms of the health care setting attended meetings to develop detailed proposals to provide access to healthcare for a significant portion of Utahns with incomes below 200% of the Federal Poverty Level (FPL). The group discussed the following issues as possibilities to consider implementing. First, an expansion of Community Health Clinics (CHC) and the safety-net, with mobile clinics and clinics next to emergency rooms as components. Second, a cost-sharing model (based on the Muskegon County model). Third, an expansion/buy-in program. This particular model would provide subsidies from SCHIP or Medicaid funds to buy into private employer plans. Fourth, a single-payer plan, a non-profit health insurance plan covering every Utahn for all medically-necessary services. Finally, a primary care and community expansion model with an employer component was proposed.

These policy options were not selected because of fiscal and/or non-viability. An extensive list of policy options is available in the comprehensive report.

The following options were proposed and considered by our workgroup participants, but due to a variety of factors, they did not receive the detailed attention like our previous proposals.

- **Employers provide a basic primary care package or low-cost insurance**
  This option is now available with the passage of House Bill 122, as described above. Several commercial carriers are marketing new insurance products that meet the intent of HB122.

- **Allow employers to buy-in to Community Health Center (CHC) care**
  After consideration of such a program, workgroup participants concluded that it would cause administrative burden and unnecessary effort for coverage lacking a catastrophic component

- **Implement clinics next to Emergency Rooms in order to divert the high cost of non-emergency care**
  This idea was still considered a plausible option, but it did not specifically address the grant's goal of providing *coverage* for the target population.

- **Develop/expand a mobile clinic system for rural areas**

This proposal was viewed as part of expanding safety net services. The mobile clinic system already exists with a fair amount of success, but it would only serve a small segment of the grant's target population.

- **Add an employer catastrophic component to the PCN**

There was concern over the fact that the PCN only covered primary care, and workgroup participants wanted to ensure that further effort would be made to increase the amount of care covered under the PCN. An 1115 waiver amendment was recently submitted to HHS that would provide a subsidy ($50 pm/pm) for PCN enrollees to buy-in to their employer's health care plan. This effort is hopefully one step toward more inclusive coverage for individuals eligible for the PCN.

- **Increase education and outreach for health programs with a Community Health Worker component**

This proposal is still considered a necessary service in Utah, but it did not address the specific goal of the grant to develop options that increase coverage. Increasing education and outreach was a major theme of our focus group study. Focus group participants related their detachment from the process and cost of health care. Increasing the consumer's awareness of how the health care system works could potentially result in more efficient and responsible consumption of services.

- **Restructure Medicaid spend-down**

Efforts from Utah Issues and Representative Becky Lockhart helped in the passage of House Bill 37 during the 2003 Legislative session. This will allow the Health Department to use 100% of the FPL as the income standard (instead of the previous spend-down amount of $382/mo.) to determine Medicaid eligibility for aged, blind, and disabled individuals.

- **Home health mid-level provider network**

This proposal was an innovative and revolutionary approach to the manner in which health care is administered today. Its idea to use mid-level providers to provide primary care in the home has potential success, but because of its non-traditional structure and untested effects, it did not receive further attention.

- **Single Payer System**

This proposal received a considerable amount of attention. The idea was presented to and commented on by the grant's Steering Committee. Doctor Joseph Q. Jarvis developed his version of such a system in Utah and continues to advocate for a single payer system throughout the state. Although the proposal would provide coverage to all Utahns, it was not pursued further for two reasons. First, HRSA requested that proposals be more incremental in nature. Second, based on the political nature of Utah and the success of single payer proposals in Vermont and Massachusetts, the proposal was deemed politically unviable.

- **Vouchers for individuals to buy insurance through employers**

This proposal could be similar to the subsidy that would be provided to PCN enrollees, or to the Premium Assistance Program in Massachusetts. The idea of vouchers did not receive extensive support.

- **Expand options with Medical Savings Accounts (MSAs)**

This proposal still has potential to increase access to health care in Utah, but it would not serve the lower-income, target population of the grant.

- **Employer Mandates (public or private)**

Mandates are not popular in Utah

- **Individual Mandates (public or private)**

Mandates are not popular in Utah. Even with the mandate for individuals to have car insurance, the rate of coverage is still approximately only 75%.

4.19 How will your State address the eligible but not enrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe your efforts to collaborate with partners at the county and municipal levels.

The Department of Health uses a combined strategy to identify individuals eligible for existing programs. An example of strategies used include:

- Coordinating with allied agencies to distribute information and provide presentations on eligibility determination
- Development of advertising material for a number of State health programs with links to Medicaid and CHIP

In addition to these strategies listed above, Utah has recently simplified enrollment into Medicaid by shortening the length of the application and implementing policies to prevent "over verification." Applications for CHIP and PCN are now available online to make enrollment more accessible. The most recent figures show 45% of CHIP applications and 9% of PCN applications are currently made online.

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

The project was governed by a Steering Committee composed of twelve community leaders representing the following groups and agencies:

- Rural Health Providers
- Utah Department of Health
- Ethnic Health Agencies
- Utah Health Insurance Association
- National Federation of Independent Business (representing small employers)
- Utah Issues (advocates for Utah's low-income population)
- Utah Medical Association
- University of Utah Center for Health Policy
- Local Health Departments/Utah County Health Department
- Utah Hospital Association
- Native American Tribes

How were key State agencies identified and involved?

The primary state agency involved was the Department of Health's Office of Children's Insurance and Access Initiatives. Many divisions within the department were consulted and information shared.

Other agencies were involved initially via invitation to an all-day CU 2002 Partnership Summit meeting (details are included in Section 5.2).

How were key constituents incorporated into the governance design?

Key constituencies included in the workgroups (i.e., legislature, community advocates, providers, administrators) reported to the Steering Committee. As mentioned, the Steering Committee itself included groups and agencies necessary for success of the grant. While proposals were being developed, consistent communication was maintained between the workgroup members.

How were key state officials in the executive and legislative branches involved in the process?

The Insurance Commissioner's office, legislators and legislative staffs were invited to the initial CU 2002 Summit. The few legislators who attended actively participated in the break out sessions and some of the follow-up workgroup meetings. State officials were also invited to a two-day session on Three-Share Programs. The co-chair of a legislative task force on health care attended and took a significant interest in exploring ways to make the program work in Utah. Finally, the CU 2002 staff has conducted interviews with legislators to acquire a better perspective of what key decision makers think about health care access, and what the role of government can be to ensure adequate access.

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?

Early in the project (June 18, 2001), a "Partnership Summit" was held for all interested parties. Invitations were mailed to over 600 people representing a wide range of organizations and interests. The summit consisted of attendees organizing into four workgroups according to their own interests. Workgroups were charged with developing proposals for covering the uninsured that would be presented to the project steering committee after a period of eight weeks.

Workgroups elected their own chairperson at the Partnership Summit. Workgroups were originally structured as follows:

Public workgroup

- Expansion Programs
  - Chip (present program in Utah)
  - Medicaid (present program in Utah)
- Single Payer
- "Direct" provision of care

Private workgroup

- Employer Based
- Tax Incentives
- Subsidies
- Medical Savings Account
- Reinsurance/stop loss

Public/Private workgroup

- Expansion Programs
  - Chip
  - Medicaid
- High Risk Pool

Community-wide workgroup

- Combine elements from other workgroups to provide coverage

We also conducted 17 focus groups throughout the State of Utah. The average number of participants, per focus group, was 10 people per session. Research consultants with the HRSA grant facilitated the focus groups, and funding came strictly from HRSA.

The distribution assured that researchers obtained a geographically representative sample of individual views, in both rural and urban areas, about the experience and consequences of being uninsured. Focus group questions were aimed to provide a deeper understanding of the barriers involved in being uninsured or on public assistance.

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, web-site development)?

We developed a web-site where many of our grant activities are posted (http://.health.utah.gov/hrsa). We included meeting schedules and minutes on the web-site as well as a "Med-line" style database containing a searchable database of health care coverage related literature.

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

The planning effort raised awareness of issues and it brought attention to legislators. It also brought about a collaboration of legislators and advocacy groups.

The planning effort raised a broader awareness of the issues that exist within the State of Utah related to the lack of or inadequate access to health services. It also assisted health care constituents, advocacy groups, and State legislators coming together for improved communication on health care coverage issues.

6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

State-specific data is only beginning to have an impact on the decision-making process. The SPG program enabled Utah to begin collecting information at a level that will become invaluable as each community looks for solutions to providing adequate health care to its residents. Because of the diversity within the State, the ability to collect data specific to each of the local health districts is imperative for making informed state funding decisions and taking advantage of federal programs.

In addition, it is important to identify the segment of the population truly unable to afford health insurance and the segment for which health insurance isn't valued. Programs aimed at expanding coverage must be appropriately focused in order to be of any benefit in reducing the number of uninsured in the state.

6.2 Which of the data collection activities was most effective relative to resources expended in conducting the work?

The focus groups and key informant interviews were the most informative and cost-effective data collection activities. The information collected through these activities reflects the attitudes, opinions, and experiences of hundreds of patients and providers in Utah.

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

We were unable to conduct Spanish-speaking focus group activities due to methodological difficulties and time constraints. We were also unable to conduct employer focus groups due to methodological difficulties. We were also planning to have an external program evaluation consultation team review our work and make recommendations. As we have recently procurred a no cost extension, this is one of the activities that we will pursue in the coming year.

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

Based on previous experiences with Utah surveys and advice from national survey vendors, we included small incentives to improve response rates for our Discrete Choice, Employer, and PCN Health Status surveys. These included $1 bills, gel pens, or 20-minute calling cards, depending on the size of the survey and the nature and extent of the information we were asking for. In addition, we made advance phone calls to the businesses randomly selected to participate in our employer survey to identify a contact person with knowledge of employee benefits, verify the address, and gain preliminary agreement to participate in the survey. Follow-up postcards and phone calls were made to non-responders.

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under HRSA grant? Does the state have plans to conduct that research?

Many questions of significant policy relevance remain. State entities are divided on the issue of affordability and much remains to be learned with regard to cultural preferences and effective

ways to increase preventive health behaviors. The issue of uncompensated care, including the various forms such care takes and the overall cost, is still being studied with the help of Brigham Young University and SHADAC.

6.6 What organizational or operational lessons were learned during the courses of the grant? Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

The impact of information gathered during the course of the grant continues to grow as the reports are disseminated to stakeholders. At the very least, it seems that a fresh perspective has been achieved among decision makers with regard to the magnitude of the problem and potential solutions. The HRSA activities provided a new forum for communication among decision makers, advocates, providers and individuals.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

New Health Insurance products are being offered in Utah's insurance marketplace in reponse to House Bill 122, which authorizes commercial primary care policies much like the Primary Care Network. For example, Regence BlueCross BlueShield is offering a product called Blue Choices. This product is an employee health care plan that allows employees to make their own choices about benefits and premium levels based on individual needs.

What were your key lessons in how to work most effectively with the employer community in your State?

We had more success gathering and disseminating information by working through groups, like the Utah Chapter of the National Federation of Independent Business, and local Chambers of Commerce. In general, the employers are busy or are pessimistic with regard to attempts to expand employer coverage in the State, and just didn't want to take the time. Capitalizing on opportunities to attend their meetings and make brief presentations or engage in brief discussion seemed to be more successful than contacting individuals for interviews or focus groups.

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

We have four main recommendations:

- First, take advantage of national databases.
- Second, get qualitative data to augment the numbers from the quantitative data collected.
- Third, collaborate.
- Fourth, hire a national consultant who already has a thorough knowledge of the national environment and what other states have done.

6.9 How did your State's political and economic environment change during the course of your grant?

<u>Economic Changes</u>

Utah's economy slowed during 2001, especially after September 11, 2001. Utah's recession continued throughout 2002. Unemployment hovered near 6.0 percent for the year and

nonagricultural employment fell 1.0 percent during the same period. From 2001 to 2003, Utah's population has grown 3.6 percent.

Political Changes
In 2001, under a recently approved Medicaid waiver, Utah adults age 19-64 with incomes under 150% of the Federal Poverty Level were eligible for coverage under a new "Primary Care Network" insurance plan.

A change in leadership also occurred.

HB 122 Health Insurance Benefit Design was passed. The act amends provisions related to Accident and Health Insurance. The act permits a carrier to offer less or different coverage than the basic benefit package, the minimum standards required by the commissioner of insurance, or any other health insurance mandate required by the state law when the Department of Health offers similar coverage as a Medicaid waiver. The act requires the Department of Health and the Insurance Commissioner to report to the Legislature on the implementation of the benefit package in the public and private sector and on partnerships between the public and private sector to increase access to health insurance.

6.10 How did your project goals change during the grant period?

When we started the grant in April of 2001, the economy was somewhat stable, although at a slight downturn. Our focus was more on ways to increase and expand coverage to those without access to health care. We felt that there were funds out there to capture, we simply had to be creative and convince constituents to invest in health programs. Once we experienced an economic downturn after 9/11, we quickly abandoned hopes of expanding programs and started looking at ways to preserve what was already in place. Our goals now are to recommend cost containment strategies that might free up current dollars and continue to provide coverage.

6.11 What will be the next steps of this effort once the grant comes to a close?

We will disseminate the information that we have gathered to all constituents and hope that the collaboration, momentum, and interest will continue. Some of the cost containment recommendations are being discussed in this year's legislative session, and the dialog should continue once the grant comes to a close.

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

The PCN proposal required waivers in the following areas:

1. Statewideness – Section 1902(a)(1)
2. Amount, Duration, Scope – Section 1902(a)(10)(B), 42 CFR 440.230-250
3. Comparability – Section 1902(a)(10)(B)
4. Enrollment Fee – Section 1902(a)(14)
5. Freedom of Choice – Section 1902(a)(23)
6. EPSDT – Section 1902(a)(43)(A)

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

Instead of looking at specific coverage expansions and the changes in Federal law that would be required, we looked at general barriers that prevent or reduce quality and /or access to health care. We came up with an extensive list of state, Federal, and market policies that are prohibitive, but will only include a few in this abbreviated version. For the complete list, refer to the comprehensive report.

- Cost of prescription drugs
- Illegal and Legal immigrant laws
- Lack of information dissemination/education/outreach for health care available
- Disconnect between the purchase and consumption of health care
- Interface between law and medicine. Criminalization of medicine and malpractice
- Small business tax law
- Reimbursement rates for Medicare and Medicaid

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

One of the realities of data collection activities is that by the time the information is collected, analyzed and distributed, it's already out of date. This is especially true when major world events occur and cultural and economic effects change drastically in a short time. The information we collected prior to or just after September 11 is clearly inadequate for today's decisions. The lesson is that data collection must be ongoing and subjected to sophisticated analysis that includes trending based on current events and previous experiences. Ongoing national support and technical advice will be even more important now that many states have increased state level data collection and are trying to understand what those numbers might mean. In sum, financial support for surveys and information collection is only half of the need. Access to national expertise in interpreting the information and applying it to health policy is the other half.

7.4 What additional research should be conducted (either by Federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

More information on uncompensated care, cost-shifting, and overall strain on the "safety net" is needed. Better understanding of cost drivers and opportunities for cost containment would be helpful to decision makers. The role of primary and preventive care in future cost containment needs to be more carefully documented so that available funds can be more effectively allocated.